

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

## Attachment 6.2

RFP No. 31786-00105

### TECHNICAL PROPOSAL & EVALUATION GUIDE

**SECTION A: MANDATORY REQUIREMENTS.** The Proposer must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Proposer must also detail the proposal page number for each item in the appropriate space below.

The RFP Coordinator will review the proposal to determine if the Mandatory Requirement Items are addressed as required and mark each with pass or fail. For each item that is not addressed as required, the Proposal Evaluation Team must review the proposal and attach a written determination. In addition to the Mandatory Requirement Items, the RFP Coordinator will review each proposal for compliance with all RFP requirements.

<b>PROPOSER LEGAL ENTITY NAME:</b>		Innovative Resource Group, Inc. LLC d/b/a APS Healthcare Midwest	
<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section A— Mandatory Requirement Items</b>	<b>Pass/Fail</b>
		The Proposal must be delivered to the State no later than the Proposal Deadline specified in the RFP Section 2, Schedule of Events.	
		The Technical Proposal and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., <i>et. seq.</i> ).	
		The Technical Proposal must NOT contain cost or pricing information of any type.	
		The Technical Proposal must NOT contain any restrictions of the rights of the State or other qualification of the proposal.	
		A Proposer must NOT submit alternate proposals.	
		A Proposer must NOT submit multiple proposals in different forms (as a prime and a sub-contractor).	
42-23	A.1.	Provide the Proposal Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.	
43	A.2.	Provide a statement, based upon reasonable inquiry, of whether the Proposer or any individual	

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		<p>who shall perform work under the contract has a possible conflict of interest (<i>e.g.</i>, employment by the State of Tennessee) and, if so, the nature of that conflict.</p> <p>NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.</p>	
43	A.3.	Provide a current bank reference indicating that the Proposer's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.	
43	A.4.	Provide two current positive credit references from vendors with which the Proposer has done business written in the form of standard business letters, signed, and dated within the past three (3) months.	
43-44	A.5.	<p>Provide EITHER:</p> <p>(a) an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a positive credit rating for the Proposer (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.); OR</p> <p>(b) a Dun &amp; Bradstreet short-form report, verified and dated within the last three (3) months and indicating a positive credit rating for the Proposer.</p>	
44	A.6.	<p>Submit a written statement indicating that the Proposer's health management and wellness services units proposed as part of this proposal meet the following minimum qualifications:</p> <p>(a) The Proposer is serving, at the time of proposal</p>	

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<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section A— Mandatory Requirement Items</b>	<b>Pass/Fail</b>
		<p>submission, one or more groups of at least one hundred thousand (100,000) members;</p> <p>(b) The above group(s) have been under contract for at least two (2) years at the time that the Proposer submits this proposal; and</p>	
44-47	A.7.	<p>Provide contact information (including contact name, email address, and phone number) for three (3) clients currently receiving health management and wellness services from the Proposer that meet the following criteria:</p> <p>(a) Each client has a minimum of five thousand (5,000) members; and</p> <p>(b) At least two of the clients have a minimum of thirty thousand (30,000) members; and</p> <p>(c) Each client has had a contract with the Proposer for at least three (3) years at the time that the Proposer submits this proposal.</p> <p>(d) Proposers that intend to subcontract the functions in Contract Section A.4., A.5, A.6, and A.7 should provide three references for all major subcontractors.</p>	
47	A.8.	<p>Submit a written statement indicating that the Proposer agrees there will be no minimum participation requirements as part of this Contract. The Contractor shall not require that a minimum percentage or number of eligible members be enrolled with a Contractor, and the State shall not guarantee that a certain percentage or number of potential members will enroll with a Contractor.</p>	
47-48	A.9.	<p>Submit a written statement, signed by an individual authorized to bind the Proposer, indicating that the Proposer will agree to host an onsite review of its offices and capabilities, by the State and the State's authorized representatives, for the purpose of</p>	

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		verifying any of the representations made by the Proposer in its proposal. This onsite review may include, but is not limited to the business office(s), information systems including website/ webportal capabilities; lifestyle management, disease management and case management operations; and member services call center and nurse advice line operations.	
48	A.10.	Submit a written statement, signed by an individual authorized to bind the Proposer, indicating that the Proposer will obtain National Committee for Quality Assurance (NCQA) accreditation and URAC accreditation as required in Contract Sections A.13.h. and A.13.i. and referenced in Contract Section A.22.	
48	A.11.	<b>TEXT DELETED</b>	
48	A.12.	Submit a written statement, signed by an individual authorized to bind the Proposer, acknowledging that <u>ALL</u> examples and illustrations that the Proposer includes in its Technical Proposal constitute an offer to provide the same such service or product in Tennessee for the administrative fees that the Proposers bids its Cost Proposal <u>UNLESS</u> the Proposer prominently explicitly states in bolded, capital letters beside each separate, excepted example that "THIS SPECIFIC EXAMPLE IS FOR ILLUSTRATION PURPOSES ONLY AND WILL NOT BE PROVIDED TO THE STATE UNDER THIS CONTRACT FOR THE ALL-INCLUSIVE ADMINISTRATIVE FEES BID IN THIS RFP."	
<b>State Use – RFP Coordinator Signature, Printed Name &amp; Date:</b>			

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**SECTION B: GENERAL QUALIFICATIONS & EXPERIENCE.** The Proposer must address all items detailed below and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Proposer must also detail the proposal page number for each item in the appropriate space below. Proposal Evaluation Team members will independently evaluate and assign one score for all responses to Section B—General Qualifications & Experience Items.

<b>PROPOSER LEGAL ENTITY NAME:</b>		Innovative Resource Group, Inc. LLC d/b/a APS Healthcare Midwest
Proposal Page # (Proposer completes)	Item Ref.	Section B: General Qualifications & Experience Items
49	B.1.	Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the proposal.
49	B.2.	Describe the Proposer's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).
49	B.3.	Detail the number of years the Proposer has been in business.
49-50	B.4.	Briefly describe how long the Proposer has been performing the services required by this RFP.
50-51	B.5.	Describe the Proposer's number of employees, client base, and location of offices.
51	B.6.	Provide a statement of whether there have been any mergers, acquisitions, or sales of the Proposer within the last ten years. If so, include an explanation providing relevant details.
51	B.7.	Provide a statement of whether the Proposer or, to the Proposer's knowledge, any of the Proposer's employees, agents, independent contractors, or subcontractors, proposed to provide work on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled nolo contendere to any felony. If so, include an explanation providing relevant details.

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<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section B: General Qualifications &amp; Experience Items</b>
51-52	B.8.	Provide a statement of whether, in the last ten years, the Proposer has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.
52	B.9.	<p>Provide a statement of whether there is any material, pending litigation against the Proposer that the Proposer should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Proposer's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Proposer's performance in a contract pursuant to this RFP.</p> <p><b>NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Proposer must be properly licensed to render such opinions. The State may require the Proposer to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.</b></p>
52	B.10.	<p>Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Proposer. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Proposer's performance in a contract pursuant to this RFP.</p> <p><b>NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Proposer must be properly licensed to render such opinions. The State may require the Proposer to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.</b></p>

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<b>53-68</b>	<b>B.11.</b>	Provide a brief, descriptive statement detailing evidence of the Proposer's ability to deliver the services sought under this RFP (e.g., prior experience, training, certifications, resources, program and quality management systems, etc.).
<b>69-83</b>	<b>B.12.</b>	Provide a narrative description of the proposed project team, its members, and organizational structure along with an organizational chart identifying the key people who will be assigned to accomplish the work required by this RFP, illustrating the lines of authority, and designating the individual responsible for the completion of each service component and deliverable of the RFP.
<b>83-85</b>	<b>B.13.</b>	Provide a personnel roster listing the names of key people who the Proposer will assign to perform duties or services required by this RFP along with the estimated number of hours that each individual will devote to that performance. Follow the personnel roster with a resume for each of the people listed. The resumes must detail the individual's title, education, current position with the Proposer, and employment history.
<b>86-89</b>	<b>B.14.</b>	<p>Provide a statement of whether the Proposer intends to use subcontractors to accomplish the work required by this RFP, and if so, detail:</p> <ul style="list-style-type: none"> <li>(a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each;</li> <li>(b) a description of the scope and portions of the work each subcontractor will perform;</li> <li>(c) a description of how the Proposer will monitor and evaluate subcontractor performance; and</li> <li>(d) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Proposer's response to this RFP.</li> </ul> <p>Subcontractor includes any entity that will provide any administrative service for the Proposer related to fulfilling the requirements of the</p>

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<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section B: General Qualifications &amp; Experience Items</b>
		Contract, including but not limited to health screenings, call center and nurse advice line, lifestyle management program(s), disease management program(s), case management program(s), and member website/portal management.
89-95	B.15.	<p>Provide documentation of the Proposer's commitment to diversity as represented by its business strategy, business relationships, and workforce— this documentation should detail all of the following:</p> <ul style="list-style-type: none"> <li>(a) a description of the Proposer's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, persons with a disability and small business enterprises;</li> <li>(b) a listing of the Proposer's current contracts with business enterprises owned by minorities, women, persons with a disability and small business enterprises, including the following information: <ul style="list-style-type: none"> <li>(i) contract description and total value</li> <li>(ii) contractor name and ownership characteristics (i.e., ethnicity, sex, disability)</li> <li>(iii) contractor contact and telephone number;</li> </ul> </li> <li>(c) an estimate of the level of participation by business enterprises owned by minorities, women, persons with a disability and small business enterprises in a contract awarded to the Proposer pursuant to this RFP, including the following information: <ul style="list-style-type: none"> <li>(i) participation estimate (expressed as a percent of the total contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics — PERCENTAGES ONLY — DO <u>NOT</u> INCLUDE DOLLAR AMOUNTS)</li> <li>(ii) descriptions of anticipated contracts</li> <li>(iii) names and ownership characteristics (i.e., ethnicity, sex, disability) of anticipated subcontractors and supply contractors anticipated; and</li> </ul> </li> <li>(d) the percent of the Proposer's total current employees by ethnicity, sex, and disability.</li> </ul>

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		<p><b>NOTE:</b> Proposers that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and sub-contractors. Proposal evaluations will recognize the positive qualifications and experience of a Proposer that does business with enterprises owned by minorities, women, persons with a disability and small business enterprises and that offers a diverse workforce to meet service needs.</p>
96-97	B.16.	<p>Provide a statement of whether or not the Proposer has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous 5-year period. If so, provide the following information for all of the current and completed contracts:</p> <ul style="list-style-type: none"> <li>(a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract;</li> <li>(b) the procuring State agency name;</li> <li>(c) a brief description of the contract's scope of services;</li> <li>(d) the contract term; and</li> <li>(e) the contract number.</li> </ul> <p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>▪ Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score, and the existence of such contracts with the State will not automatically result in the addition or deduction of evaluation points.</li> <li>▪ Each evaluator will generally consider the results of inquiries by the State regarding all contracts noted.B.1. Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the proposal.</li> </ul>
97-98	B.17.	<p>Provide customer references from five individuals (who are not current or former officials or staff of the State of Tennessee) for projects similar to the services sought under this RFP and which represent:</p> <ul style="list-style-type: none"> <li>▪ two (2) of the larger accounts currently serviced by the Proposer,</li> </ul>

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		<p>within the envelope provided;</p> <p>(iv) sign his or her name in ink across the sealed portion of the envelope; and</p> <p>(v) return the sealed envelope containing the completed reference questionnaire directly to the Proposer (the Proposer may wish to give each reference a deadline, such that the Proposer will be able to collect all required references in time to include them within the sealed Technical Proposal).</p> <p>(d) Do NOT open the sealed references upon receipt.</p> <p>(e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Proposal as required.</p> <p><b>NOTES:</b></p> <ul style="list-style-type: none"> <li>▪ The State will not accept late references or references submitted by any means other than that which is described above, and each reference questionnaire submitted must be completed as required.</li> <li>▪ The State will not review more than the number of required references indicated above.</li> <li>▪ While the State will base its reference check on the contents of the sealed reference envelopes included in the Technical Proposal package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references.</li> <li>▪ The State is under no obligation to clarify any reference information.</li> </ul>
<b>98-99</b>	<b>B.18.</b>	For each of calendar years 2006, 2007, 2008, and 2009 provide the average number of total members for the top five largest accounts for which you have provided health management and wellness services. Identify the type of account (e.g., commercial, Medicare, or Medicaid).
<b>99-101</b>	<b>B.19.</b>	Describe your safeguards to protect the privacy and confidentiality of all members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain

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		related to the medical benefits covered in this Contract. Please also describe any security breaches involving more than one hundred (100) members during the last two (2) years and explain the corrective actions that you are taking to mitigate risks for any future breaches.
102	B.20.	<p>Provide a statement of whether, within the past five (5) years, either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any) has had a contract to provide health management and wellness services:</p> <p>(a) terminated prior to the contract end date; or</p> <p>(b) ended without the procuring party exercising a contract option to extend the contract;</p> <p>If so, include an explanation of all relevant details. Specify whether or not the termination or decision not to exercise a contract extension option resulted from performance issues, and if so, detail any corrective action taken by the Proposer to address the issues.</p>
102-103	B.21.	<p>Describe fully each instance (if any), within the last five (5) years, in which a federal or state regulatory entity has:</p> <p>(a) imposed, against either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any), a debarment or suspension, regulatory action, or sanction (including both monetary and non-monetary sanctions) relating to medical claims administration contract(s); or</p> <p>(b) issued, to either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any), a letter of deficiency or of corrective actions requested or required relating to medical claims administration contract(s).</p>
103	B.22.	Provide a statement of whether, currently or within the past five (5) years, either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any) has been the subject of a criminal or

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		civil investigation by a state or federal agency other than investigations described in response to items B.8. and B.10. If so, provide a detailed explanation of all relevant details as well as the outcome (if the matter was concluded).
103-107	B.23.	Provide a description of your organization's relevant accreditations, including but not limited to your current National Committee for Quality Assurance (NCQA) and URAC, formerly the Utilization Review Accreditation Commission accreditation status, as well as any awards or superior performance recognitions. Please provide data on your Disease Management (DM) performance measures in the area of Comprehensive Diabetes Care (including all measures, if available) for your three largest programs. Please provide the measures for every year in which you operated that program and, if applicable, any baseline measures. As part of your response please include the contact at the organization who received the data and explain any confounding factors that may explain, in whole or in part, the changes in the performance measures.
107-108	B.24.	Describe your business continuity and disaster recovery plans for all information systems including your system back-up processes.
<p><b>SCORE (for <u>all</u> Section B—Qualifications &amp; Experience Items above):</b> <input type="text"/></p> <p><b>(maximum possible score = 20)</b></p> <p><i>State Use – Evaluator Identification:</i></p>		

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### TECHNICAL PROPOSAL & EVALUATION GUIDE

**SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH.** The Proposer must address all items (below) and provide, in sequence, the information and documentation as required (referenced with the associated item references). The Proposer must also detail the proposal page number for each item in the appropriate space below.

A Proposal Evaluation Team, made up of three or more State employees, will independently evaluate and score the proposal's response to each item. Each evaluator will use the following whole number, raw point scale for scoring each item:

**0 = little value    1 = poor    2 = fair    3 = satisfactory    4 = good    5 = excellent**

The RFP Coordinator will multiply the Item Score by the associated Evaluation Factor (indicating the relative emphasis of the item in the overall evaluation). The resulting product will be the item's raw, weighted score for purposes of calculating the section score as indicated.

<b>PROPOSER LEGAL ENTITY NAME:</b>		Innovative Resource Group, Inc. LLC d/b/a APS Healthcare Midwest			
Proposal Page # (Proposer completes)	Item Ref.	Section C— Technical Qualifications, Experience & Approach Items	Item Score	Evaluation Factor	Raw Weighted Score
109-117	C.1.	<p>Provide a project implementation plan describing the steps that the Proposer will take upon approval of a contract resulting from this RFP to be prepared to assume all responsibilities described in the Pro Forma Contract (RFP Attachment 6.6) as of the go-live date specified in Pro Forma Contract Section A.22. Include the following:</p> <p>(a) an itemization of activities that the proposer will undertake during the period between the awarding of this procurement and the start date of the program. These activities shall have established</p>		3	

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		<p>deadlines and timeframes and as needed conform to the timelines established under this RFP;</p> <p>(b) tasks associated with the proposer's establishment of a "project office" or similar organization by which the proposer will manage the implementation of the health management and wellness program;</p> <p>(c) a roster of the implementation team members detailing each member's primary work location, roles, and responsibilities;</p> <p>(d) a comprehensive description of activities related to information systems, including data interfacing/integration with critical systems and intake and assimilation of transition data;</p> <p>(e) identification of proposer expectations regarding participation by the State and/or its agents in the activities in the plan and dependencies between these activities and implementation activities for which the State and/or its agents will be responsible.</p> <p>(f) the dates on which the implementation team would share first drafts of the health questionnaire, risk stratification</p>			

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		<p>approach (including method for identifying and enrolling members into health management and wellness programs, as indicated) and related member materials and web resources that the implementation team would propose to use for this project;</p> <p>(g) the project timeline and a schedule of meetings between the implementation team and the State; and</p> <p>(h) anticipated frequency of updates to the implementation plan.</p>			
<b>117-121</b>	<b>C.2.</b>	<p>For the proposed Account Team for this Contract describe:</p> <p>(a) how the implementation team will be phased out and replaced by the ongoing Account Team and provide projected dates;</p> <p>(b) how the Proposer will ensure a smooth transition between the teams with minimal disruption to the State and members and whether the Proposer would commit to extending on a temporary basis the work of key implementation team (c) how the Account Team will work with the State, outside of regularly scheduled meetings, to identify opportunities and respond to issues that arise in the industry to ensure the State manages its</p>		<b>2</b>	

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		<p>medical benefits in a timely, cost effective, and judicious manner;</p> <p>(d) how the Account Team will escalate, as necessary, and resolve issues of importance to the State; and</p> <p>(e) any evaluation tools that the Proposer offers for State use in providing formal written evaluation of the Account Team's performance, the projected frequency of such feedback and how the Proposer will use it to improve performance.</p>			
<b>121-126</b>	<b>C.3.</b>	<p>Describe how, for this contract, you will coordinate and organize the employment site screening events, including: (a) Registering members, informing them of the events and scheduling appointments; and</p> <p>(b) Managing the planning and scheduling logistics.</p> <p>Describe the qualifications of the individuals who will be administering the employment site health screens under this contract. What training will they receive? How will you ensure the provision of quality screening and counseling?</p> <p>To the extent that you will allow/ encourage members to obtain screens at laboratories/patient services center</p>		<b>4</b>	

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		under this Contract, describe how you will ensure that members get all necessary elements of the health screening (e.g., height/ weight and blood pressure). Also, describe the data transmission from said entities and how you will ensure members receive counseling after the screens.			
126-128	C.4.	Describe how, under this Contract, you will provide immediate feedback to the member upon completion of the health screening at any onsite event. Specifically, describe how you will explain to the member the meaning of the results. Additionally, provide a sample one-page feedback summary and any other education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece).		2	
128-129	C.5.	Describe how, for this Contract, you will ensure that all data from the health screens are accurately transferred and stored (e.g., specifically describe how data will be transferred from the collection site and secured/stored in your office/facility). Please describe this process for employment site screening events and at-home screening and laboratories/patient services centers (if applicable).		1	
129	C.6.	Describe how, for this Contract, you		3	

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		will receive health screening information from physicians and other providers who provide health screenings in their offices. In what specific ways can the providers submit the information to you? How will you address situations in which the provider supplied incomplete information – or data in a format different than that you requested? What (if any) confirmation of receipt do you provide to the member? Also, what follow-up counseling or education would they receive – and would they receive this by phone, mail or other medium? Please provide the same information for laboratories/ patient services centers (if applicable).			
130-131	C.7.	<p>Provide the paper version and screen shots of the online version of the health questionnaire that you propose to use under this Contract (and the current Flesch-Kincaid reading level of the questionnaire). You may also include an HTML version of your online health questionnaire by storing it on a writeable CD-R and including it with your technical proposal.</p> <p>Also, describe the following:  (a) The estimated average time that it takes a member to complete the questionnaire;</p>		6	

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		<p>(b) The process that you used to determine or establish content validity and measure the reliability* of the health questionnaire; and</p> <p>(c) The distinguishing strengths and comparative advantages of your health questionnaire.</p> <p>Please reference (and include, if possible) any peer-reviewed publications in which this health questionnaire featured prominently as a data collection tool.</p> <p>In addition, describe the process and timeframes for making any State-requested customizations or changes to the health questionnaire and your ability to comply with or exceed the flexibility requirements in Contact Section A.4.b.</p> <p>* See, e.g., Carmines, Edward G. and Richard A. Zeller. Reliability and Validity Assessment, Quantitative Applications in the Social Sciences Series Paper #17, Sage University Press: Newberry Park, CA, 1979.</p>			
<b>132</b>	<b>C.8.</b>	Describe how, under this Contract, you will provide feedback to the member upon completion of the health questionnaire. Provide summaries of your process for both online and paper		<b>2</b>	

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		questionnaires. Additionally, provide any education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece).			
132-146	C.9.	<p>Describe how, for this Contract, you will develop a wellness score/risk assessment for each member. In particular:</p> <p>(a) Describe the factors used in the scoring, the relative weights associated with each factor (or member response), and both the wellness/risk categories and proposed thresholds for intervention; and</p> <p>(b) Detail the challenges associated with making changes to the methodology and the steps you will take to address any challenges.</p> <p>Please explain how your assessment methodology would “score” the following individuals. To the extent that you need to make assumptions, please do so and state these assumptions in your response.</p> <p>1. Jane, a 29-year-old pregnant female full-time employee in Murfreesboro, Tennessee with no</p>		6	

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		<p>known medical conditions who self-reports that she uses tobacco;</p> <p>2. Ezekial, a 59-year-old male retiree in Union City, Tennessee who indicates depressed mood for at least two months in duration and whose body mass index (37) indicates that he is morbidly obese; and</p> <p>3. Fleeta, a 40-year-old female spousal dependent in Knoxville, Tennessee of normal height and weight whose biometrics reveal both elevated blood pressure (159/90) and total cholesterol of 239.</p> <p>Also, explain if and how you would ascertain that each of these three members (i) has type II diabetes; (ii) has had a heart attack in the preceding three years or (iii) has a history of lower back pain and is currently considering back surgery.</p> <p>Please also specify the extent to which you will also use medical claims data. Describe the specific types of data that you will require and your expectations of both the State and the State's Decision Support Services vendor to provide these data to you. Please note:</p>			

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		<p>The State is unlikely to approve any approach that involves direct claims feeds from the medical third party administrators (rather than from the Decision Support Services vendor).</p> <p>In addition, describe the process and timeframes for making any State-requested changes to your methodology and your ability to comply with or exceed the flexibility requirements in Contact Sections A.5.h. and A.5.j.</p>			
<b>146-147</b>	<b>C.10.</b>	<p>Given that members could complete the health questionnaire before or after the health screening, describe the type of feedback you will provide and the way in which you will deliver it to communicate your holistic assessment of a member's health risks under this Contract. Explain how this larger communication relates to the post-screening and post-questionnaire information and materials that you will have provided. Additionally, provide any education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece). Finally, explain what follow-up and reminder contacts you will make to members who registered by February 14 but who have not completed either or both the health questionnaire or health</p>		<b>3</b>	

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		screening.			
147-157	C.11.	<p>Describe your process, for this Contract, for enrolling members in lifestyle management, disease management, and case management, including the method, frequency, and timeframes for engagement and whether this varies by condition, member risk, or other methodology.</p> <p>Explain the specific steps that you will take to ensure that members do not receive multiple, duplicative or uncoordinated contacts from your staff, the medical TPAs, the PBM, and the EAP/BHO regarding the same or similar issues.</p> <p>Additionally, while the RFP identifies lifestyle management, disease management, and case management as separate programs, the Contractor shall implement these as a continuum of services. Describe how you will accomplish this both internally and with members.</p>		3	
157-161	C.12.	Describe your proposed staffing model for the coaches and case managers required under this Contract. As part of this description please describe the coach/case manager to member ratios you will use (if any),		4	

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		<p>how you will ensure all coaches and case managers have the appropriate required qualifications and the training you will employ for coaches/case managers. Regarding your process for assigning coaches/case managers under this Contract, describe:</p> <p>(a) How coaches/case managers will be assigned to particular participants, e.g. risk level, condition, geography, and/or other;</p> <p>(b) At what point in the process individual coaches/case managers will be assigned to a particular member/participant;</p> <p>(c) How members with two or more conditions are managed (e.g., single coach/case manager or team);</p> <p>(d) If you would assign teams to a member, describe when and how this will happen; and</p> <p>(e) Your process for transitioning members to new coaches/case managers, including changes initiated by the Contractor and by the member.</p>			

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162-182	C.13.	<p>Regarding each of your lifestyle management programs under this Contract for the conditions listed in Contract Section A.7.r., describe or provide the following:</p> <p>(a) Your criteria for enrollment, including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment;</p> <p>(b) Specific examples of how you integrate evidence-based guidelines and other best practices;</p> <p>(c) The frequency and method(s) of interactive contact and other interventions with members;</p> <p>(d) The length of each program, including all options;</p> <p>(e) The performance standards for your health coaches;</p> <p>(f) Ongoing training provided to your health coaches;</p> <p>(g) Your most recent annual turnover rate and average and maximum coach to participant ratio;</p>		6	

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		<p>(h) Samples of your program materials for weight management, tobacco cessation, high cholesterol and hypertension (along with the Flesch-Kincaid reading level of each piece);</p> <p>(i) The level of physician involvement and the ongoing use of your medical director(s) and physician consultant(s);</p> <p>(j) Follow-up provided when a participant is referred to his/her physician; and</p> <p>(k) Copies of published studies or research that provide evidence that each of your lifestyle management interventions are effective.</p>			
<b>182-207</b>	<b>C.14.</b>	<p>Regarding each of your disease management programs under this Contract for the conditions listed in Contract Section A.7.s., describe or provide the following:</p> <p>(a) Your criteria for enrollment, including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment</p>		<b>8</b>	

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		<p>in the program and any risk level(s);</p> <p>(b) Specific examples of how you integrate evidence-based guidelines and other best practices in each disease management program;</p> <p>(c) The frequency and method(s) of interactive contact and other interventions with members for each disease management program;</p> <p>(d) How you incorporate collaborative practice models that include physician and support-service providers;</p> <p>(e) The average length of each program;</p> <p>(f) The qualifications of your health coaches;</p> <p>(g) The performance standards for your health coaches;</p> <p>(h) Ongoing training provided to your health coaches;</p> <p>(i) Your most recent annual turnover rate and average and maximum coach to participant ratio;</p>			

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		<p>(j) Samples of your program materials for diabetes, depression, and morbid obesity (along with the Flesch-Kincaid reading level of each piece);</p> <p>(k) The level of physician involvement and the ongoing use of your medical director(s) and physician consultant(s);</p> <p>(l) Coordination with providers and EAP/BHO, PBM, and medical TPAs; and</p> <p>(m) Copies of published studies or research that provide evidence that each of your disease management program interventions are effective.</p>			
<b>207-226</b>	<b>C.15.</b>	<p>Regarding your case management program for this Contract, describe or provide the following:</p> <p>(a) Your criteria for enrollment including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment in the program and any risk levels;</p> <p>(b) Specific examples of how you integrate evidence-based guidelines and other best</p>		<b>5</b>	

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		<p>practices;</p> <p>(c) The frequency and method(s) of interactive contact and other interventions with members;</p> <p>(d) The average length of case management;</p> <p>(e) The qualifications of your case managers;</p> <p>(f) The performance standards for your case managers;</p> <p>(g) Ongoing training provided to your case managers;</p> <p>(h) Your most recent annual turnover rate and average and maximum case manager to participant ratio;</p> <p>(i) Your plan and script for outbound contact with a potentially pregnant member in order to screen the member's risks;</p> <p>(j) Samples of your program materials for high risk pregnancy (along with the Flesch-Kincaid reading level of each piece);</p> <p>(k) The level of physician involvement and the ongoing use of your</p>			

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		<p>medical director(s) and physician consultant(s);</p> <p>(l) Coordination with providers and State vendors; and</p> <p>(m) Copies of published studies or research that provide evidence that your case management interventions are effective.</p>			
226-231	C.16.	<p>Review the scenario below and respond to each of the questions. Please provide as much operational detail as possible in your response in order to illustrate with a case example the mechanics of the programs that you described above.</p> <p>Scenario: James is a 41-year-old male with no history of chronic disease, but he self-reports that he uses tobacco, and that he is largely sedentary. His biometric results indicate elevated cholesterol, and various pieces of information suggest that he may be pre-diabetic. Explain how your process would work, assuming that he took the health questionnaire on January 15 and the biometric screening in May 2. Please provide exact dates for each contact or intervention. Please also explain what pieces of information that you would use to make a preliminary conclusion</p>		2	

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		<p>that he is pre-diabetic. Three months after being enrolled in the module or program on the continuum of health coaching and health management services, you receive a notice from James' medical third party administrator that he is being released from the hospital. What follow up action would you take? You eventually learn that James suffered a massive heart attack and is having a slow recovering and has not returned to work. What types of action would you take (if any)? Eight months later, after James has returned to work, he reports that he has stopped using tobacco and brought his cholesterol down. He is also engaging in some limited physical activity each day. Explain your triggers and process for transitioning James to less-intensive levels of service (either now or in the future).</p>			
<b>232-236</b>	<b>C.17.</b>	<p>Describe your clinical management software capabilities to document individual treatment/care plans, member communication with coaches/case managers, and continuity between coaches/case managers. Please discuss only those capabilities that you will use under this Contract.</p> <p>In addition, describe what, if any, in-</p>		<b>3</b>	

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		field biometric monitoring (e.g., glucose monitors, blood pressure monitoring, or scales) that you will make available to complex patients who participate in disease management or case management under this Contract. Which specific members, if any, will have access to these resources? Is automated data transmission available?			
<b>237-242</b>	<b>C.18.</b>	Describe the specific performance measures you will use for this Contract to measure the percent and numbers of people who graduate from the program(s) in which they are enrolled, the percent and numbers of people who show behavioral changes and/or clinical improvements in accordance with their individualized goals.		<b>2</b>	
<b>243-247</b>	<b>C.19.</b>	With respect to your work under this Contract, to what extent will you incorporate patient decision-making tools (e.g., DVDs, etc.) that attempt to empower participants to make informed choices regarding various treatment modalities (e.g., physical therapy versus back surgery, prostatectomy versus radiation therapy, diet and exercise versus different bariatric procedures, etc.)? Which decision aids do you believe are		<b>3</b>	

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		the most effective? What evidence about the efficacy and cost-effectiveness did you use to guide your decision in this regard?			
247-251	C.20.	Describe your process for engaging or re-engaging poorly adherent Partnership PPO members who are enrolled in lifestyle management, disease management, or case management programs under this Contract. In addition, describe your strategies for this Contract to re-engage participants who disenroll from lifestyle management, disease management, or case management.		2	
251-252	C.21.	Describe the monitoring program for lifestyle coaching, DM and case management calls under this Contract. For example, is there a 100 percent review or random sampling; two-way silent monitoring, one-way monitoring, taped calls or some combination? State the percentage and frequency of calls that will be monitored for this Contract for each of the three program types: lifestyle coaching, DM and case management.		1	
252-256	C.22.	Provide an example (annotated screen shots and narrative) of Web-based functionality that you propose to use under this Contract. At a minimum,		6	

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		<p>include a description and Screenshots of:</p> <p>(a) The user registration and management process,</p> <p>(b) Inquiry and response capabilities,</p> <p>(c) Worksite screening event search/locator functionality,</p> <p>(d) Worksite screening event scheduling,</p> <p>(e) Disease management “portals” for at least two in-scope chronic disease states listed in Contract Section A.7.s.</p> <p>In your descriptions/narratives, highlight aspects/features of your site/page design and associated functionality that you would characterize as strengths.</p>			
256-258	C.23.	Describe the features and ease of use of the online journaling and the other types of online and paper-based tools you propose to use pursuant to Contract Section A.12.k. Please provide sample materials to the extent possible.		3	
258-264	C.24.	Describe or provide the following		4	

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		<p>information about data reporting under this Contract:</p> <p>(a) the Proposer's standard reporting package, inclusive of report names, numbers of reports, methods of distribution, and refresh frequency, and whether the reports required by the Pro Forma Contract are included;</p> <p>(b) the type and duration of information systems and reporting tools training that the Proposer will provide State staff during implementation; the qualifications and credentials of the trainers; and whether the training can be performed on-site at a State location;</p> <p>(c) the generation and provision to the State of the key reports prescribed in the Contract (Section A.21 of the Contract);</p> <p>(d) The standard reports and related ad hoc reports that you would recommend and propose to provide under this Contract;</p> <p>(e) the Proposer's ad hoc reporting capabilities— address State access to an ad hoc reporting liaison to assist in the development of ad</p>			

**A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**Attachment 6.2**

**RFP No. 31786-00105**

<b>PROPOSER LEGAL ENTITY NAME:</b>		Innovative Resource Group, Inc. LLC d/b/a APS Healthcare Midwest			
<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section C— Technical Qualifications, Experience &amp; Approach Items</b>	<b>Item Score</b>	<b>Evaluation Factor</b>	<b>Raw Weighted Score</b>
		<p>ad hoc report requests as well as the extent to which authorized State staff will have access to the Proposer's system(s) for the purpose of creating and generate ad hoc reports;</p> <p>(f) the payment reports that the Proposer will provide to the State to assist the State in reconciling payment detail and recording accounting entries.</p> <p>(g) The ability in a secure, inquiry-only environment for authorized State staff and providers to view certain aggregate data and create and/or generate reports on an ad-hoc basis.</p> <p>Please provide samples of all referenced reports and screen shots of all referenced online systems to which the State will have direct access.</p>			
<b>264-277</b>	<b>C.25.</b>	<p>Describe or provide the following information regarding the call center infrastructure that the Proposer offers in the performance of under this Contract:</p> <p>(a) The operations of call center(s) including the location of call</p>		<b>5</b>	

**A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**Attachment 6.2**

**RFP No. 31786-00105**

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		<p>center(s), hours of operation, staffing projections, and plans for rerouting of calls and in what circumstances that may happen;</p> <p>(b) The flexibility of the call center to handle fluctuations in call volume resulting from program, benefit or enrollment changes, and address related equipment, its scalability and flexibility, and the proportion of its capacity currently in use;</p> <p>(c) A sample of the call center statistics that will be available to the State;</p> <p>(d) Call monitoring sessions regularly conducted by the call center or in coordination with the State;</p> <p>(e) Capabilities to accommodate hearing and visually impaired members;</p> <p>(f) Information systems support for the call center member services representatives, including tracking calls/correspondence and access to other data (e.g., claims data, provider information);</p> <p>(g) Back-up call center operational readiness in the event of a natural disaster, etc.</p>			

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**RFP No. 31786-00105**

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<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section C— Technical Qualifications, Experience &amp; Approach Items</b>	<b>Item Score</b>	<b>Evaluation Factor</b>	<b>Raw Weighted Score</b>
		(h) Procedures for monitoring and ensuring the quality of services provided by member services call center staff and customer satisfaction. Please provide details about the sample size for monitoring, the type (e.g. two-way silent monitoring, one-way monitoring, taped calls, or a combination of methods.			
277-278	C.26.	Please provide responses to these same questions in the item immediately preceding this one for the nurse advice line for this Contract. In addition, for the nurse advice line, explain how, for this Contract, your nurse advice line will provide referrals to network providers, e.g., convenience clinics and urgent care centers, based on the member's location. Also, describe the process you will use for this Contract to ensure that information collected by the nurse advice line staff will be transmitted to the member's coach/case manager.		4	
278-282	C.27.	Describe the preventive health messaging plan you propose to employ under this Contract. As part of this description please address all required messaging articulated in Contract Section A.11.s.		3	

**A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**Attachment 6.2**

**RFP No. 31786-00105**

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<b>Proposal Page # (Proposer completes)</b>	<b>Item Ref.</b>	<b>Section C— Technical Qualifications, Experience &amp; Approach Items</b>	<b>Item Score</b>	<b>Evaluation Factor</b>	<b>Raw Weighted Score</b>
282	C.28.	Describe in detail the process and procedures that the Proposer will follow to ensure that the reading level requirements of Contract Section A.11.I. are met. To the extent that current Proposer materials do not comply with the required standards, include a comprehensive explanation of the proposed approach for revising them to read at or below the 6.0 reading level.		1	
282-289	C.29.	Describe the specific information systems that the Proposer will use for this Contract. Specifically address:  (a) any modifications to existing hardware and software that will be required;  (b) the extent to which these information systems are already in operation;  (c) the timeframe for any implementation of components not currently in operation; and  (d) the capabilities and the expertise of the staff/personnel dedicated to support information system operations.		2	
289-292	C.30.	Describe or provide the following information regarding data integration		1	

**A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**Attachment 6.2**

**RFP No. 31786-00105**

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		<p>and technical requirements under this Contract:</p> <p>(a) the ability to ensure the accurate and timely processing of enrollment files including eligibility additions, changes, and deletions based on a standard 834 file supplied by the State as described in Appendix 7.7.;</p> <p>(b) the quality control processes that will be used to ensure the accurate and complete update of eligibility files as well as how eligibility errors will be communicated to the State; and</p> <p>(c) the process for loading historical data from the current claims administrators and validating the completeness and integrity of said data, if applicable.</p>			
<p><i>The RFP Coordinator will use this sum and the formula below to calculate the section score. All calculations will use and result in numbers rounded to two(2) places to the right of the decimal point.</i></p>			<p><b>Total Raw Weighted Score:</b> (sum of Raw Weighted Scores above)</p>		
<p><b>Total Raw Weighted Score</b> <b>Maximum Possible Raw Weighted Score</b> (i.e., 5 x the sum of item weights above)</p>			<p><b>X 50</b> (maximum possible score)</p>		<b>= SCORE:</b>
<p><i>State Use – Evaluator Identification:</i></p>					
<p><i>State Use – RFP Coordinator Signature, Printed Name &amp; Date:</i></p>					

# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**RFP No. 31786-00105**

## **Section A: Mandatory Requirements**

**The Proposal must be delivered to the State no later than the Proposal Deadline specified in the RFP Section 2, Schedule of Events.**

As specified in the RFP Section 2, Schedule of Events, APS' proposal has been delivered to the State no later than the Proposal Deadline.

**The Technical Proposal and the Cost Proposal documentation must be packaged separately as required (refer to RFP Section 3.2., *et. seq.*).**

As required, APS' Technical Proposal and Cost Proposal documentation has been packaged separately.

**The Technical Proposal must NOT contain cost or pricing information of any type.**

APS' Technical Proposal does not contain cost or pricing information of any type.

**The Technical Proposal must NOT contain any restrictions of the rights of the State or other qualification of the proposal.**

APS' Technical Proposal does not contain any restrictions of the rights of the State or other qualifications of the proposal.

**A Proposer must NOT submit alternate proposals.**

APS, the Proposer, has not submitted alternate proposals.

**A Proposer must NOT submit multiple proposals in different forms (as a prime and a sub-contractor).**

APS has submitted one (1) proposal as the prime contractor.

**A.1. Provide the Proposal Statement of Certifications and Assurances (RFP Attachment 6.1.) completed and signed by an individual empowered to bind the Proposer to the provisions of this RFP and any resulting contract. The document must be signed without exception or qualification.**

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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RFP No. 31786-00105

APS has provided the Proposal Statement of Certifications and Assurances (RFP Attachment 6.1) completed and signed by Jerry Vaccaro, President and Chief Operating Officer, without exception or qualification, within the tab marked "6.1 Proposal Statement of Certifications/Assurances."

**A.2. Provide a statement, based upon reasonable inquiry, of whether the Proposer or any individual who shall perform work under the contract has a possible conflict of interest (e.g., employment by the State of Tennessee) and, if so, the nature of that conflict.**

**NOTE: Any questions of conflict of interest shall be solely within the discretion of the State, and the State reserves the right to cancel any award.**

Neither APS (the Proposer) nor any individual who shall perform work under the contract has a possible conflict of interest.

**A.3. Provide a current bank reference indicating that the Proposer's business relationship with the financial institution is in positive standing. Such reference must be written in the form of a standard business letter, signed, and dated within the past three (3) months.**

APS has provided a current bank reference as **Exhibit B** indicating that our business relationship with B, the financial institution, is in positive standing.

**A.4. Provide two current positive credit references from vendors with which the Proposer has done business written in the form of standard business letters, signed, and dated within the past three (3) months.**

APS has provided two (2) current, positive credit references letters from vendors with which we have done business, as **Exhibit C**.

**A.5. Provide EITHER:**

- (a) an official document or letter from an accredited credit bureau, verified and dated within the last three (3) months and indicating a positive credit rating for the Proposer (NOTE: A credit bureau report number without the full report is insufficient and will not be considered responsive.); OR**
- (b) a Dun & Bradstreet short-form report, verified and dated within the last three (3) months and indicating a positive credit rating for the Proposer.**

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**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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APS has provided a Dun & Bradstreet report, verified and dated within the last three (3) months, which indicates a positive credit rating APS as **Exhibit D**.

### **A.6. Submit a written statement indicating that the Proposer's health management and wellness services units proposed as part of this proposal meet the following minimum qualifications:**

- (a) The Proposer is serving, at the time of proposal submission, one or more groups of at least one hundred thousand (100,000) members;**
- (b) The above group(s) have been under contract for at least two (2) years at the time that the Proposer submits this proposal; and**

APS confirms that our health management and wellness services units proposed as part of our proposal meet the following minimum qualifications:

- At the time of proposal submission, APS serves one or more groups of at least one hundred thousand (100,000) members;
- The above group(s) have been under contract for at least two (2) years at the time of proposal submission.

### **A.7. Provide contact information (including contact name, email address, and phone number) for three (3) clients currently receiving health management and wellness services from the Proposer that meet the following criteria:**

- (a) Each client has a minimum of five thousand (5,000) members; and**
- (b) At least two of the clients have a minimum of thirty thousand (30,000) members; and**
- (c) Each client has had a contract with the Proposer for at least three (3) years at the time that the Proposer submits this proposal.**

<b>Client Name:</b>	Schering-Plough
<b>Contact Name:</b>	Teri Pazos, Sr. Benefits Manager
<b>Email Address:</b>	<u>teresa.pazos@spcorp.com</u>
<b>Phone Number:</b>	908-298-7418
<b># of Members:</b>	34,200 lives
<b># of Years as APS Client:</b>	Over 3 years

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

<b>Client Name:</b>	The State of Wyoming, EqualityCare (Medicaid) Program
<b>Contact Name:</b>	Michelle Harker, Medical Care Coordinator
<b>Email Address:</b>	<a href="mailto:michelle.harker@health.wyo.gov">michelle.harker@health.wyo.gov</a>
<b>Phone Number:</b>	307-777-5854
<b># of Members:</b>	55,000
<b># of Years as APS Client:</b>	Over 5 years

<b>Client Name:</b>	The State of Missouri, Missouri Chronic Care Improvement Program
<b>Contact Name:</b>	Jayne Zemmer, Program Manager
<b>Email Address:</b>	<a href="mailto:Jayne.A.Zemmer@dss.mo.gov">Jayne.A.Zemmer@dss.mo.gov</a>
<b>Phone Number:</b>	573-751-1612
<b># of Members:</b>	154,000
<b># of Years as APS Client:</b>	Over 3 years

**(d) Proposers that intend to subcontract the functions in Contract Section A.4., A.5, A.6, and A.7 should provide three references for all major subcontractors.**

For the State's Health Management & Wellness Program, APS has chosen to partner with leading specialty companies to deliver the entire scope of the State's Program and complement our own expertise. This includes partnering with eDoc4U for a health questionnaire and online lifestyle management programs; Summit Health for onsite health screening services; Carenet for 24/7 Nurse Line services; and Vanderbilt Institute for Obesity and Metabolism (Vanderbilt) for advisory and consultation services regarding our Morbid Obesity Program. References for each of our subcontractors are provided in the following tables.

SUBCONTRACTOR	eDoc4U
<b>Client Name:</b>	Saint Thomas Health Systems
<b>Contact Name:</b>	Rebecca Climer, Chief Operating Officer
<b>Email Address:</b>	<a href="mailto:rclimer@stthomas.org">rclimer@stthomas.org</a>
<b>Phone Number:</b>	(615) 284-6839
<b>Client Name:</b>	Morehouse School of Medicine
<b>Contact Name:</b>	Dr. John Maupin, President
<b>Email Address:</b>	<a href="mailto:jmaupin@msm.edu">jmaupin@msm.edu</a>
<b>Phone Number:</b>	(404) 752-1740
<b>Client Name:</b>	ACS Healthcare Solutions
<b>Contact Name:</b>	David Joiner, Vice President, Strategic Initiatives
<b>Email Address:</b>	<a href="mailto:david.joiner@ACS-HCS.com">david.joiner@ACS-HCS.com</a>
<b>Phone Number:</b>	(615) 692-1675

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

SUBCONTRACTOR	Summit Health
Client Name:	UnitedHealthcare
Contact Name:	Andie Rowe, Director, Health Education & Prevention Programs
Email Address:	It is Summit Health's policy to not disclose customer email addresses.
Phone Number:	(301) 545-5576
Client Name:	Blue Cross Blue Shield of Minnesota
Contact Name:	Dr. Patrick B. Herson, VP & Medical Director, Major Accounts and Consumer Strategy
Email Address:	It is Summit Health's policy to not disclose customer email addresses.
Phone Number:	(651) 662-2594
Client Name:	Highmark (Blue Cross of Pennsylvania)
Contact Name:	Bob Adams, Preventive Health Services Director
Email Address:	It is Summit Health's policy to not disclose customer email addresses.
Phone Number:	(412) 544-6170

SUBCONTRACTOR	Carenet
Client Name:	City of Pasadena
Contact Name:	Anita Arevalo, Program Coordinator
Email Address:	aarevalo@cityofpasadena.net
Phone Number:	(626) 744-6054
Client Name:	Harmony Illinois
Contact Name:	Shawn Cull, Senior Network Development Specialist
Email Address:	shawn.cull@wellcare.com
Phone Number:	(312) 777-5054
Client Name:	USFHP
Contact Name:	Cynthia Trapani, Manager of Member Services
Email Address:	cynthia.trapani@usfhpchristus.org
Phone Number:	(281) 936-7082

\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\*

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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SUBCONTRACTOR	Vanderbilt Institute for Obesity and Metabolism
Client Name:	Tennessee State University
Contact Name:	Pamela Carmen Hull, Ph.D., Center for Health Research
Email Address:	pamhull@tnstate.edu
Phone Number:	615-320-3005
Client Name:	The Meharry-State Farm Alliance
Contact Name:	Irwin Goldzweig, Director Injury Prevention Unit, Department of Family and Community Medicine
Email Address:	igoldzweig@mmc.edu
Phone Number:	(615) 327-6142
Client Name:	Vanderbilt University
Contact Name:	James W Pichert (Ph.D.), Professor of Medical Education and Administration, Co-Dir, Center for Patient & Professional Advocacy
Email Address:	jim.pichert@Vanderbilt.Edu
Phone Number:	615-343-4500 (3-4500 on campus)

**A.8. Submit a written statement indicating that the Proposer agrees there will be no minimum participation requirements as part of this Contract. The Contractor shall not require that a minimum percentage or number of eligible members be enrolled with a Contractor, and the State shall not guarantee that a certain percentage or number of potential members will enroll with a Contractor.**

APS confirms that there will be no minimum participation requirements as part of this Contract. APS will not require that a minimum percentage or number of eligible members be enrolled with APS, and the State will not guarantee that a certain percentage or number of potential members will enroll with APS.

**A.9. Submit a written statement, signed by an individual authorized to bind the Proposer, indicating that the Proposer will agree to host an onsite review of its offices and capabilities, by the State and the State's authorized representatives, for the purpose of verifying any of the representations made by the Proposer in its proposal. This onsite review may include, but is not limited to the business office(s), information systems including website/webportal capabilities; lifestyle management, disease management and case management operations; and member services call center and nurse advice line operations.**

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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RFP No. 31786-00105

A written statement affirming the above and signed by APS' President and Chief Operating Officer, Jerry Vaccaro, who can bind APS has been provided as **Exhibit E**.

**A.10. Submit a written statement, signed by an individual authorized to bind the Proposer, indicating that the Proposer will obtain National Committee for Quality Assurance (NCQA) accreditation and URAC accreditation as required in Contract Sections A.13.h. and A.13.i. and referenced in Contract Section A.22.**

A written statement affirming the above and signed by APS' President and Chief Operating Officer, Jerry Vaccaro, who can bind APS has been provided as **Exhibit F**.

**A.11 QUESTION DELETED PER AMENDMENT #2, DATED MAY 18, 2010**

**A.12. Submit a written statement, signed by an individual authorized to bind the Proposer, acknowledging that ALL examples and illustrations that the Proposer includes in its Technical Proposal constitute an offer to provide the same such service or product in Tennessee for the administrative fees that the Proposer bids its Cost Proposal UNLESS the Proposer prominently explicitly states in bolded, capital letters beside each separate, excepted example that "THIS SPECIFIC EXAMPLE IS FOR ILLUSTRATION PURPOSES ONLY AND WILL NOT BE PROVIDED TO THE STATE UNDER THIS CONTRACT FOR THE ALL-INCLUSIVE ADMINISTRATIVE FEES BID IN THIS RFP."**

A written statement affirming the above and signed by APS' President and Chief Operating Officer, Jerry Vaccaro, who can bind APS has been provided as **Exhibit G**.

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**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

## **Section B: General Qualifications & Experience Items**

### **B.1. Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the proposal.**

The individual that the State should contact regarding our proposal is provided below:

**Name:** Daniel Poch  
**Title:** Vice President, Sales  
**Address:** APS Healthcare  
44 South Broadway  
White Plains, NY 10601  
**Office:** (513) 745-8795  
**Cell:** (513) 288-4353  
**E-mail:** [dpoch@apshealthcare.com](mailto:dpoch@apshealthcare.com)

### **B.2. Describe the Proposer's form of business (i.e., individual, sole proprietor, corporation, non-profit corporation, partnership, limited liability company) and business location (physical location or domicile).**

APS is a private, for-profit, limited liability company, incorporated in the State of Iowa. Our corporate headquarters are located in White Plains, New York. Upon contract award, APS will establish a local service center in Tennessee to administer the State's Health Management & Wellness Program. This is the model APS has used for our clients in 26 other states and Puerto Rico.

### **B.3. Detail the number of years the Proposer has been in business.**

APS is a national specialty healthcare company dedicated to achieving optimal health outcomes while containing costs for both our private and public sector clients. The bidding entity, Innovative Resource Group, Inc. LLC d/b/a APS Healthcare Midwest (APS), was originally established in 1985 via CNR Partners, Inc. Our parent company – APS Healthcare Bethesda, Inc. – was formed in 1992 and acquired APS Healthcare Midwest in March of 2002.

### **B.4. Briefly describe how long the Proposer has been performing the services required by this RFP.**

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

**RFP No. 31786-00105**

APS has been providing integrated wellness and disease management services required by the State's RFP for 15 years as well as medical utilization and case management services for 16 years. We have also provided behavioral health utilization and case management for 15 years and employee assistance programs for 24 years.

## **B.5. Describe the Proposer's number of employees, client base, and location of offices.**

APS has over 1,700 employees. Headquartered in White Plains, New York, we have office locations across the United States and Puerto Rico including but not limited to Florida, Georgia, Ohio, Missouri, West Virginia, Pennsylvania, Maryland, Texas, California, Oregon and Hawaii. For each of our state customers, we employ our local service center model whereby we establish a local office staffed with professionals from the surrounding communities. By recruiting and hiring qualified professionals from the same communities where our customers' members live and work, these individuals have a better understanding of the provider community, geography and the community's cultural make-up and nuances to better serve members. Additionally, our local staff is fully supported by our corporate and national resources. We employ seasoned industry experts across the country who are available to lend their specific expertise as well as "lessons learned" from administering similar programs. This combination of national experience with local knowledge is an ideal combination for Tennessee's program to be a success. Furthermore, given the service center's close proximity to the State's personnel, our local model enables our staff to easily communicate with the State to facilitate discussions regarding the program's performance as well as resolve issues as they arise. We have achieved success in delivering responsive, quality services to our customers as our local model provides a superior level of attention to both their members and the providers that serve them.

APS provides wellness services, disease management and case management in both the public and private sectors. Our client-base includes government employers, corporate employers, Taft-Hartley Trust Funds, health plans, and Medicaid state agencies. In fact, APS and its related entities support hundreds of clients across the United States and Puerto Rico representing more than 20 million lives via a wide spectrum of uniquely structured programs. We currently serve 53 government entities, including 38 Medicaid programs, through contracts in 26 states and Puerto Rico.

Our programs include Population Health Management (PHM) services delivered to broad populations that encompass the entire health care continuum – from the healthy to seriously ill. Our PHM services, which are reflective of the services requested by the State, include a collaborative, flexible mix of program services inclusive of wellness and prevention for all members, and disease management, case management, complex care coordination, palliative

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

care, and utilization management and review services for the most costly members.

### **B.6. Provide a statement of whether there have been any mergers, acquisitions, or sales of the Proposer within the last ten years. If so, include an explanation providing relevant details.**

APS is a wholly owned subsidiary of APS Healthcare Bethesda, Inc. In June of 2007, GTCR Golder Rauner, LLC (GTCR), one of the nation's leading private equity firms, teamed with Greg Scott, Jerry Vaccaro and other senior managers to recapitalize APS. GTCR is the ultimate parent company of APS Bethesda through Partners Healthcare Solutions Holdings, LP. GTCR is a leading private equity investment firm and a long-term strategic partner for outstanding management teams. H.I.G. Capital, APS' previous majority investor, and other investors sold their interests in the company as a result of the transaction. As part of the transaction, industry veteran Greg Scott, formerly Chief Financial Officer of PacifiCare succeeded Eileen Auen as our Chairman and Chief Executive Officer. Jerry Vaccaro, M.D., formerly President and CEO of PacifiCare Behavioral Health, joined Scott and is now APS' President and Chief Operating Officer.

Prior to this, APS Healthcare Bethesda acquired Innovative Resources Group (IRG) d/b/a APS Healthcare Midwest in 2002 to increase our depth of informatics and health management capabilities, as well as Sheppard Pratt Health System in 2001 to expand our EAP and behavioral healthcare business.

### **B.7. Provide a statement of whether the Proposer or, to the Proposer's knowledge, any of the Proposer's employees, agents, independent contractors, or subcontractors, proposed to provide work on a contract pursuant to this RFP, have been convicted of, pled guilty to, or pled *nolo contendere* to any felony. If so, include an explanation providing relevant details.**

APS, and to the best of APS' knowledge, our employees, agents, independent contractors and subcontractors proposed to provide work on a contract pursuant to this RFP, have not been convicted of, pled guilty to or pled *nolo contendere* to any felony.

### **B.8. Provide a statement of whether, in the last ten years, the Proposer has filed (or had filed against it) any bankruptcy or insolvency proceeding, whether voluntary or involuntary, or undergone the appointment of a receiver, trustee, or assignee for the benefit of creditors. If so, include an explanation providing relevant details.**

APS has not filed (and has not had filed against it) any bankruptcy or insolvency proceeding,

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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**RFP No. 31786-00105**

whether voluntary or involuntary, or undergone the appointment of a receiver, trustee or assignee for the benefit of creditors.

**B.9. Provide a statement of whether there is any material, pending litigation against the Proposer that the Proposer should reasonably believe could adversely affect its ability to meet contract requirements pursuant to this RFP or is likely to have a material adverse effect on the Proposer's financial condition. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it would impair the Proposer's performance in a contract pursuant to this RFP.**

**NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Proposer must be properly licensed to render such opinions. The State may require the Proposer to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.**

There is no material, pending litigation against APS that could affect its ability to meet contractual requirements pursuant to this RFP or is likely to have a material adverse effect on APS' financial condition.

**B.10. Provide a statement of whether there are any pending or in progress Securities Exchange Commission investigations involving the Proposer. If such exists, list each separately, explain the relevant details, and attach the opinion of counsel addressing whether and to what extent it will impair the Proposer's performance in a contract pursuant to this RFP.**

**NOTE: All persons, agencies, firms, or other entities that provide legal opinions regarding the Proposer must be properly licensed to render such opinions. The State may require the Proposer to submit proof of such licensure detailing the state of licensure and licensure number for each person or entity that renders such opinions.**

There are no pending or in progress Securities Exchange Commission investigations involving APS.

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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**B.11. Provide a brief, descriptive statement detailing evidence of the Proposer's ability to deliver the services sought under this RFP (e.g., prior experience, training, certifications, resources, program and quality management systems, etc.).**

## **APS – A Qualified Health Management & Wellness Proposer**

APS has thoroughly reviewed the RFP and is in alignment with the State's stated purpose, goals and objectives. We understand that in order for the State to preserve more comprehensive, affordable and dependable health coverage with minimum cost-shifting to members, the State needs to partner with a health management and wellness vendor that can provide a full continuum of health management and wellness services to improve the health of members of your public sector plans. APS applauds the State for incentivising its plan members to make the "Partnership Promise" to become engaged in their health and healthcare decisions. Our proposed Health Management & Wellness Program is designed to fully support these members in achieving their health care goals by helping them make positive behavior changes and take actions to reduce their health risks. Our program offers a variety of health-focused tools and services (e.g., health questionnaire, health screenings, decision support tools) as well as staff – from Lifestyle Management Health Coaches to Disease Management Health Coaches to Case Managers—who are adept at educating, engaging and advocating for members regarding their health and healthy behaviors. APS has outlined our key strengths below that demonstrate our capability to effectively deliver the Health Management & Wellness program the State envisions.

## **Program-Specific Experience**

APS has a proven track record in delivering integrated health management and wellness programs. We have supported an integrated approach to PHM, which employs the collaborative care model, and builds on our proven track record in managing comparable populations – from member and provider outreach, to engagement to interventions – in other statewide health management programs such as Ohio, Missouri, Wyoming, Oregon and Vermont. In these programs, we have employed population-based tools to engage members and providers to optimize members' health and well-being; achieved improvements in quality, cost-effective care; and achieved targeted cost savings.

APS has developed a model that is person-centered and provider-supportive; a model that addresses members' overall health status as well as social, emotional and economic issues that may prevent appropriate self-management. The success of the State's program will be driven by APS' specific knowledge, experience, and success in implementing the principles of the Chronic Care Model as we have done in other statewide health management programs. The Chronic Care Model, developed by Edward Wagner, MD, MPH, and colleagues at his center,

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Improving Chronic Illness Care (ICIC)<sup>1</sup>, emphasizes patient self-management, integration of community resources into a model of coordinated services, increased emphasis on primary care, and application of evidence to the selection of practice guidelines and behavioral interventions. The Chronic Care Model (CCM) identifies the essential elements of a health care system that encourage high-quality chronic disease care. Our operational approach has been one of continuous improvement and enhancement of every statewide health management program we have launched. As a result, our services and experience make us an ideal partner to meet this RFP's primary qualifications.

Certain individuals/populations experience disproportionately higher rates of obesity and other chronic diseases. Differences exist in attitudes and cultural norms regarding body weight. Although the rates of obesity have risen in all categories of adults in Tennessee, the rates are disproportionately higher for African Americans, and obesity is most prevalent among black females. The rate of obesity among adults in Tennessee is 27% for White, 38% for Black, and 36.7% for Hispanic. To be successful in managing weight and weight-related conditions, APS recognizes the need to integrate culturally appropriate strategies into our platform. Our partners at Vanderbilt University have a strong history of experience in working with disparate populations, both through behavioral interventions and community-based participatory research within the African American and Hispanic populations, and will use their expertise in the State's Health Management & Wellness Program to help ensure its success.

Our approach to health management and wellness has been at the forefront of a shift to deliver integrated, innovative programs that target the entire population and will help individuals in their efforts to achieve improved overall health. These programs provide education and outreach to encourage and support healthy behaviors for individuals of all health risk levels in addition to addressing disease-specific clinical care improvement issues.

Similar in design to the State's requested Health Management & Wellness Program is our contract with the State of Ohio. In 2007, APS was chosen to partner with the State of Ohio to deliver a "best in class" Population Health Management (PHM) program for a portion of their employee population. The State of Ohio's PHM program includes a suite of integrated programs including Disease Management, Wellness (i.e., Health Risk Assessment/Questionnaire, online disease prevention/wellness programs, health (biometric) screenings), and Nurseline services with 100% follow-up for members who engage in the PHM program's activities. APS' program model for the State of Ohio includes a Columbus, Ohio, Service Center that was established after winning the contract as well as field-based Outreach Coordinators and Health Coaches who provide program promotion and education to further engage members in the PHM program regardless of where they are in the continuum of care. During this time, APS has been

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<sup>1</sup> Wagner, E. (2006). The Chronic Care Model.

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able to deliver a comprehensive service offering that reaches as many members as possible and helps them effectively change their at-risk behaviors. Due to our successful track record serving Ohio, APS was chosen as the State of Ohio's continued PHM partner, and expanded the contract to include its remaining employee population.

Program accomplishments have included:

- The ER utilization/1000 members decreased by 8.4% in the managed group (ER utilization in the total population increased by 3%).
- The trend in the managed group was held to 6.6%. The inpatient admissions/1000 members in the total population increased by over 13%.
- For members with Diabetes, adherence with recommended HgbA1c testing protocols (one or more HgbA1C annually) improved significantly from 39% to 53% and well surpassed the 41% target.
- For members with Coronary Artery Disease (CAD), adherence with lipid (cholesterol) testing improved from 31% to 44%.
- The 24/7 nurse triage line was an important benefit recognized by the State of Ohio. A total of 2,187 calls were placed to the line with a total cost avoidance of \$84,400.

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We have also received numerous comments praising the services that APS has provided. Below are a few that we believe illustrate the level of service APS provides to the State and your employees.

About a current Ohio outreach coordinator:

*"...can get anyone to eat broccoli! She is unbelievably effective at engaging our employees and especially good at enrolling people in coaching. Her wonderful reputation has spread among our agency wellness coordinators, and she is now in much demand. We very much appreciate her work."*

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Following APS' participation in the statewide wellness consortium event:

*"Thank you so much for your help with our wellness coordinators event yesterday. We have received a number of positive comments about your presentation, and everyone is looking for that recipe and pantry list, which I understand we now have. I also appreciate the pedometers you provided to attendees. Several of us have ours on today, so I think we're all getting the health and wellness message! Thanks again for all your support."*

APS' State of Wyoming program is another excellent example of a program that promotes lifestyle modifications, compliance with treatment plans, education, and social support. The framework has been adapted from the Chronic Care Model and integrates the role of APS interventions in promoting the adoption of healthy behaviors among enrollees. It also helps to illustrate how APS' efforts strengthen the critical component of productive interactions between enrollees and their providers. We ensure program enrollees have established a relationship with a Medical Home – patient-centered provider of primary care services – to facilitate their efforts in improving their quality of life and health. We identify, assess and stratify the needs of the target population. We focus on the social context of behavioral decisions and assist members in the development of personal and social skills required to make positive health behavior choices. Appropriate levels of intervention are employed to assist enrollees in incorporating positive behaviors into their daily health care and lifestyle decisions. In addition, we generate results by supporting providers with timely, clinically actionable information.

APS has served Wyoming since July of 2004. Some of the activities of the *Healthy Together!* program include providing enrollees with toll-free, 24-hour access to a team of nurses, social workers and counselors who provide one-on-one education on making healthy decisions; and coordination of services when enrollees are hospitalized, using services inappropriately, or need help meeting their socioeconomic needs. In addition, APS' program supports healthcare providers in the community in their role in health improvement by actively promoting key prevention guidelines and by providing education on evidence-based clinical guidelines, as well as guidance on implementation of the State's Pay for Participation (P4P) program. Under the P4P program, participating providers receive increased reimbursement for referring their eligible patients to the *Healthy Together!* Program; completing specific disease, age and gender screenings; and providing health education for Medicaid patients with chronic illness.

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Additionally, APS is contracted by the Office of Vermont Health Access (OVHA) to co-manage the State of Vermont Chronic Care Initiative (VCCI). The program works in collaboration with other State initiatives aimed at improving the health status of Vermonters. The VCCI joined forces with the Vermont Blueprint for Health. The VCCI assists PCPs by providing chronic care management and patient self-management support. VCCI registered nurses and medical social workers provided telephonic and in-person health coaching on evidence-based clinical guidelines, case management for psychosocial factors, and assistance in accessing community resources. VCCI assesses patient/family preferences, readiness to change and self-management abilities and then provides culturally appropriate education, coaching and self-management resources to empower patients to become informed and active self-managers. VCCI also provides and coordinates self-monitoring tools and personal health records for the home setting.

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Another example is our contract with the State of Missouri. Since 2006, APS has provided an enhanced primary care case management program for the State of Missouri that incorporates the principles of disease management, support of the Medical Home, case management and an internet-based community health record to best serve participants identified through claims data. We have also implemented a community-based care management model which places clinical and support personnel in strategic provider locations throughout the state. Our goal is to improve participant treatment compliance through a community-based model. With the support of the Missouri Primary Care Association (MPCA), APS' community-based staff work in provider locations and perform participant outreach and chronic disease education while increasing collaboration between providers and participants. The community-based model has led to more effective care coordination, improved participant treatment plan compliance, and positive changes associated with chronic disease indicators and evidence-based practices.

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Chronic care management programs such as those APS has described above are valuable in the promotion and use evidence-based care and improved self-management. Our extensive, proven experience serves as the foundation for our proposed Health Management & Wellness Program for Tennessee.

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As with all of our programs, our model will be customized to meet the specific objectives of the State and will continuously assess its impact as well as areas for enhancement throughout the life of the program. Our areas of focus for the State's Health Management & Wellness Program will be to support the State's program objectives including the "partnership promise:"

- Help members identify and understand their health risk factors by completing a health questionnaire and/or health screening.
- Follow-up with and outreach to members to assist them in addressing their health risk factors, including reminders about receiving annual wellness checks and all necessary preventative services.
- Engaging members in a seamless continuum of health care services – lifestyle management, disease management, and case management – to help them maintain or improve their "health/wellness score" through personal actions and individual health outcomes.
- Educating members on prevention and to better self-manage their conditions, including adhering to a Medical Home.
- Encouraging providers to promote self-management among their patients.

Essential elements of our program model, which are designed to support the State's members in fulfilling their "partnership promise" include:

### **Identification and stratification:**

- A suite of analytical tools used to identify highest-risk members with chronic disease
- Analysis of "uncoordinated care behaviors", e.g., frequent emergency room (ER) use, high number of prevention quality indicator (PQI) admissions and re-admissions, multiple providers, duplicate pharmacy therapy, and low medication possession ratios (MPRs) used to identify actionable/impactable members.
- Development of a wellness score/risk assessment for each member based upon various available data sets (e.g., health questionnaire, health screening, claims data, and assessments conducted by Coaches/Case Managers).

### **Enrollment/engagement:**

- Clear and easily understandable communication plan that describes the program's services, how to access services, and the benefits of those services. This plan includes printed materials, email blasts, and a comprehensive member web-portal with access to various tools and content (e.g., health questionnaire, identifying and scheduling health screenings, disease-specific content, wellness point tracking).
- Outreach to all individuals who complete a health questionnaire for enrollment in an appropriate program as applicable (e.g., lifestyle management, disease management, case management or referrals to other State-sponsored benefits such as EAP/BHO).

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- Outreach to all individuals who complete a health screening for enrollment in an appropriate program as applicable (e.g., lifestyle management, disease management, case management or referrals to other State-sponsored benefits such as EAP/BHO).
- Outreach to members focusing on helping them understand their wellness score/risk assessment, the results of their health questionnaire and/or health screening, identifying actionable opportunities and recommendations to improve their wellness score/health and reduce their risk factors, as well as the health and financial benefits of committing to the “partnership promise.”
- Assess and provide necessary member-specific interventions including, but not limited to, health and prevention education, education around treatment options, self-management disease management or case management support.
- Establish a patient centered Medical Home (primary health care provider) as the source of primary healthcare so that they can discuss recommended actions to improve their health gained during interactions with their Health Coach/Case Manager.
- Use of a Regional, Field-based Health Team comprised of a Health Coach, Health Educator and Health Promotion Coordinator who are designated to serve a specific region/worksites—The Health Team will be recognizable “faces” of the program and be able to build positive relationships with members within their designated region/worksites during onsite activities to ultimately help them make positive behavior changes regarding their healthcare. Field-based staff will be responsible for engaging and providing health coaching services to members onsite at key State locations as well as engaging the highest-risk members while they are in-patients – this approach facilitates positive relationship building and ensure that immediate care coordination needs (e.g., healthcare home, medication adherence barriers) are assessed and managed.
- Relationships are built with the highest volume medical and behavioral health providers who are managing the most challenging members to encourage referrals.
- Preventive Messaging Plan with ongoing preventative messaging to the entire population as well as targeted health messages to targeted members on various topics including reminders for preventative services such as annual wellness checks, age/gender specific preventive health reminders (e.g., mammogram, prostate), seasonal allergies, flu vaccinations, weight management, tobacco/smoking cessation, healthy eating and exercise, for example. This plan employs various modes of communication from printed materials to email blasts to Interactive Voice Recognition (IVR) messaging to ensure we reach all members.

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## **Worksite and community-based care management (member and provider-centric) strategies employed:**

- Engage members face-to-face during health fairs, health screening events, and brown bag educational sessions to promote completion of the health questionnaire, help them understand their risk factors, and enroll them in an applicable program to address their health risks.
- Leverage the success of the patient centered Medical Home model
- Use population and provider-specific data to identify partner providers based on:
  - Their potential to improve their adoption of best practices and system/provider integration
  - Their good performance as providers and potential to act as a “Champion Provider,” a source of best practice knowledge and primary referral source for patients without a PCP
- Utilize field-based clinical staff to serve as true physician-extenders rather than “employer-sponsored monitors” and provide care coordination, monitoring and education for highest-risk members based on plan of care.
- Utilize technology – APS CareConnection® an internet-based, HIPAA-compliant care management system – and share information effectively across healthcare team members to support member and provider decision making and goals while improving the quality of care:
  - This electronic plan of care and health management tool is the backbone of APS’ improved data capture and better decision supports for evidence-based practices.
  - It will share critical information across the provider community and engage health management personnel, providers, and members in collecting and maintaining consistent care plan information.

## **Engagement Experience**

APS is extremely experienced in the area of member and provider engagement. Engagement in programs varies based on a variety of factors including how the customer defines the program, the population type (e.g., employer versus a Medicaid population), whether the program is defined as an “Opt-in” or an “Opt-out” model, as well as any caps on enrollment that the customer may impose.

We have had great success in member engagement through both our commercial and State Medicaid contracts, which we will leverage for the State of Tennessee’s program. In fact, our experience with Medicaid populations has afforded us an expertise in engagement and behavior change. As the Medicaid population has no plan-driven financial incentives to change its members’ behavior, APS’ Health Coaches and other staff employ creative motivational techniques to drive the optimal behavior change of our Medicaid membership. They do this by

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first focusing on each member's basic human needs that vary from one person to the next. Our Health Coaches are trained to understand those basic needs in individuals and use them to drive behavior change. For example, a Health Coach who is working with a diabetic with no co-morbid conditions, who is motivated to lose weight and has a strong home support system may focus on the member's nutrition, identifying achievable weekly fitness goals, accessing online weight management tools and conducting outreach every other month. On the other hand, if that diabetic was in denial about his/her diabetes, had a co-morbidity of depression, and did not have access to reliable transportation, the Health Coach would stress the importance of and make sure that he/she took the appropriate tests (e.g., hemoglobin A1c test, annual eye exam); reach out to the member's physician to involve him/her in the member's plan of care and engage the member at the point of care; facilitate linkage with the member's mental health vendor for treatment of his/her depression, and assist him/her in locating reliable transportation for doctor appointments with outreach at least on a monthly basis. For Tennessee, we will apply the same member and provider engagement techniques and proven fundamental processes to the different needs of the State's population to ensure your members are active participants in their health and well-being.

The key to our success has been deployment of our Community Health Partnership model whereby we establish a significant on-the-ground presence via staff at key worksite events (e.g., health fairs, health screenings) and partnerships with community providers. Examples of our success in this arena are demonstrated by our customer programs in Georgia, Missouri and Ohio.

**GEC:** The Georgia Enhanced Care Program (GEC) operates as an Opt-in program. In this program, 53% of the population is engaged. The program serves a disabled Medicaid population of 27,000 members throughout a 53 county area in Georgia that includes the metro Atlanta area. In March of 2009, APS undertook a combined letter and Televox campaign with one week between the receipt of the letter and the telephone call. The letter included information specific to the member including their specific condition and a call to action. The most notable results of this campaign were an increase in incoming calls per day by 91%, and an increase in assessments per day by 48%. This is one quantifiable example of how we try to improve engagement rates. The quantifiable evidence in APS' engagement success is the improvement in clinical outcomes and savings that we have achieved in this program. During the first year of the program, APS was able to save the state \$80 million, and in year two APS saved the state \$87 million. The savings estimates were validated through studies conducted by Mercer and Aon Consulting. Actual savings is probably the best evidence that members were engaged and that we engaged those whose costs we were able to impact.

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**Missouri CCIP:** The Missouri Chronic Care Improvement Program (CCIP) operates as an Opt-out program with an enrollment cap. From February 2007 to March 2009, enrolled participants in the program increased from 5,225 to 111,628. Today there are approximately 154,000 members enrolled and APS is at the state imposed cap for enrollment. In order to be considered enrolled, the member must meet the criteria for one of the gateway diseases, have seen a physician in the past 12 months, have received a welcome letter, have a plan of care developed and have a health care home assignment. Highlights of the quantifiable evidence of engagement include:

- Average risk scores for enrolled participants that were 9.5% higher than non-enrolled group
- \$157 million reduction in total annual costs
- Medical adherence rates 1.5 – 2.0 times higher in APS enrolled Medicaid patients
- Significant drops in appointment “no-show” rates (reduction >50%)
- Significant increases in blood glucose monitoring in enrolled patients (44% enrolled vs. 20% non-enrolled)
- Significant increases in cholesterol monitoring in enrolled patients (39% enrolled vs. 16% non-enrolled)
- Significant increases in medication adherence (pharmacy utilization asthma medications and cardiovascular medications—average 63% adherence in enrolled patients vs. 34% in non-enrolled)
- 3% of patients had a Medical Home at the start of the APS intervention in February 2007. Currently, 99% of enrolled patients have a Medical Home.

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**State of Ohio:** For the State of Ohio, we utilize Televox and its interactive voice response technology for phone append services and for automated outreach to all members identified for disease management but who coaches have been “unable to contact.” This automated outreach augments the outreach efforts of the program’s Health Coaches and Outreach Coordinator. Specifically, we utilize outbound messaging to contact members with a personalized message containing important health information – such as new member enrollment calls, medication compliance messages, preventive health messages and refill reminders. The messages are automatically delivered at any time we choose, including evenings and weekends. Members who receive a message can utilize touch-tone response options to ensure crucial two-way communication, including the capability to be transferred to a Health Coach. Additionally, we worked with the State to develop an eye-catching postcard to replace the “traditional” white envelope containing our “Unable to Reach You” card. Lastly, we rely on

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our Columbus-based Outreach Coordinators to gather accurate contact information and engage program participants. Outreach Coordinators are responsible for providing onsite educational activities to engage individuals; help individuals complete health questionnaires (HRAs); collect data on patients; act as a professional resource person for health education; link them with a Health Coach for coaching services; and recommend and coordinate educational and community resources based on the individual's individual needs. As a result of our efforts, the State of Ohio has improved its engagement rates. In fact, for March 2010, our engagement rate for disease management was 22.4% and 27.1% for wellness.

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## Innovative Technology

In order to effectively deliver the State's Health Management & Wellness Program, APS will employ our innovative, proprietary, web-based system solution, known as CareConnection. The APS CareConnection platform will functionally integrate data (claims, health questionnaires, health screenings, lab results, nurse line data and any other source of information) from our subcontractors - eDoc4U, Summit Health and Carenet - to deliver a seamless service to the State's public plan members while providing the State with all pertinent data and information. Our platform offers our clients, like the State, a highly developed and HIPAA-compliant system that is highly configurable to specific State requirements, effectively meeting each client's program needs. Most importantly, this system makes it possible to integrate information across various providers and disparate sources (e.g., physician offices, hospitals, health plans, pharmacy benefit managers, health risk assessment vendors, specialty laboratories, medical management companies, employee assistance programs and behavioral health providers). CareConnection also offers capabilities such as decision support, online evidence-based guidelines, and other tools for the provider community. APS CareConnection® is linked throughout all of our internal departments and is able to seamlessly integrate eligibility, clinical claims, encounter claims, pharmacy claims, health questionnaire results, health screening (biometric) data, wellness activity, information gathered from members and providers, quality improvement efforts, and supplemental data we receive from the State.

CareConnection originally debuted in 1999 as the first web-based authorization tool used in a statewide Medicaid program. Since that time, APS CareConnection® has undergone numerous enhancements with expanded capabilities that meet our other program needs, and now serves approximately 53 customers across the country.

APS will utilize this innovative web-based system tailored for use with the State's Health Management & Wellness Program. We can assure the State that this system currently provides

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functionality that meets your scope of work, and will configure this system during implementation to include specific State eligibility specifications, condition-specific plan of care algorithms, and links to the State's sites as we have done with all of our other clients.

### **APS' Focus on Provider Outreach & Partnerships**

A key element of APS' approach to delivering an effective program is building and engaging support of the program from its local community prior to submitting a proposal. In fact, we have taken this approach with other state contracts in Missouri, Georgia, Pennsylvania, Oregon and California, which has resulted in successful implementations and early program success driven by the community's support of the program. APS has applied this approach with Tennessee as we have already met with the following individuals and organizations over the past several months:

- Russ Miller, Senior Vice President; Phyllis Franklin, Director of Insurance Affairs, Tennessee Medical Association
- Cathy J. Dyer, Executive Director, Tennessee Academy of Family Physicians
- Catherine M. Fenner, Executive Director; Ruth E. Allen, EPSDT Director, Tennessee Chapter of American Academy of Pediatrics
- Beth Berry, Senior Vice President; Jill Talbert, Assistant Vice President, Advocacy and Grassroots, Tennessee Hospital Association
- Tom Starling, Ed.D., President & CEO, Mental Health Association of Middle Tennessee
- Margaret Smith, Director of Lung Health Programs; Gail Bost, Development Director; Olivia Weiss, Development Manager, American Lung Association of Tennessee
- Gordon R. Bernard, M.D., Associate Vice Chancellor for Research, Senior Associate Dean for Clinical Services, Joan Randall, MPH, Assistant Professor and Administrative Director, Vanderbilt Institute for Obesity and Metabolism; David Schlundt, Ph.D. Psychology, Institute for Obesity and Metabolism, Vanderbilt University
- Chastity Mitchell, JD, American Heart Association-Tennessee
- John Chiaramonte, Jr. Government Relations Director; Carol Minor, Health Systems Director, Tennessee, American Cancer Society
- Shelley Courington, Executive Director, CHART
- Susan Veale, Executive Assistant, Rural Health Association of Tennessee

APS has received a number of letters (See **Exhibit H**) of support and acknowledgement from these organizations.

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During our meetings with these provider organizations, APS discussed the Tennessee Department of Finance and Administration Request for Information that was issued in December 2009, focusing the discussion on the health management and wellness services area. APS solicited their suggestions on how the program could be implemented most effectively in working with their physicians and member organizations who serve the State's employees, retirees and other covered members. When the Request for Proposal was issued, APS shared copies with these organizations and pledged our commitment to collaborate with the provider and stakeholder organizations on activities in support of the goals that the Tennessee Department of Finance and Administration desires to accomplish through the Health Management and Wellness Services program. All expressed strong interest in this program and their commitment to working with APS in a collaborative manner if we are selected to administer this program. During these discussions, APS also learned about a special tobacco cessation training program that the American Lung Association has developed, and discussed how APS could incorporate it into the Health Management and Wellness Services program.

Additionally, APS recognizes the immense burden obesity has had on the health of Tennesseans. According to 2009 Behavioral Risk Factor Surveillance System data, adults in Tennessee have the third highest rate of obesity (32.8%) and overweight (36.1%). The percentage of obese and overweight children between the ages of 10 and 17 in Tennessee is 36% (4th highest in the nation, 2007 Youth Risk Behavior Survey). Eighteen percent of 9th to 12th graders are considered overweight and another 17% are obese. Researchers have shown that an obese person has \$1,429 per year more medical costs, or about 42 percent more costs, than someone of normal weight. (Finkelstein) Costs for an obese Medicare recipient are even greater. Therefore, the total annual costs of obesity-related diseases in Tennessee can be estimated as follows: Tennessee population = 6.2 million x 30.2% obesity rate x \$1429 = \$2.7 billion per year. Assuming the State employees have the same percentage of obese members, the State is paying over \$118 million for obesity related diseases. In addition to direct health care costs, obesity results in lower worker productivity, increased absenteeism, and higher workers' compensation claims than normal weight employees. Furthermore, the medical costs associated with adult obesity in Tennessee were \$1.8 billion in 2003 dollars.<sup>2</sup>

Due to the specific obesity problems facing Tennessee, APS also reached out to Joan Randall, MPH at the Institute for Obesity and Metabolism at the Department of Medicine at Vanderbilt University. Their group has conducted extensive research on obesity and diabetes in Tennessee. This includes basic and clinical research, public health research and outreach, policy development and advocacy. APS has engaged in discussions with Joan and David Schlundt of the Behavioral and Interventional Research Group related to this program. APS has engaged in discussions with Joan and David Schlundt of the Behavioral and Interventional Research Group

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<sup>2</sup> <http://www.cdc.gov/obesity/stateprograms/fundedstates/tennessee.html>, May 21, 2010.

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related to this program. Professor Schlundt has done extensive research examining the assessment of eating behavior, as well as the environmental, cognitive and emotional factors that influence behavioral strategies for the treatment of obesity. His work also examines health disparities in obesity and associated behavior, understanding how environmental factors are associated with variations in obesity prevalence and disparities, and the use of community based research strategies in the treatment and prevention of obesity. APS plans to execute a Letter of Intent to contract with the Institute to serve in an advisory and consultant capacity to APS for the Obesity Management program including leveraging its experience in community engagement, particularly as APS works with members of the program who are obese and morbidly obese. Randall and Schlundt are both members of the Steering Committee for the Tennessee Obesity Taskforce (TOT), and are working closely with partners across the state to reduce the burden of obesity in Tennessee. Two of the TOT focused work groups are *Worksite Wellness* and *Health Systems*, and strategies related to these areas are being implemented and evaluated statewide. We believe that by having Vanderbilt as our partner, APS will be able enhance and revise our intervention and education strategies with members who are at risk or already obese, benefiting from the research at Vanderbilt.

## **State Government Experience**

APS specializes in working cooperatively with government organizations to improve the health of their populations and optimize healthcare expenditures through sustainable behavior change that reinforces seeking and giving care in alignment with best practice clinical guidelines. Since implementing our first statewide total population health management program in Wyoming, we have expanded to provide customized programs across the United States, including Georgia, Missouri, Nevada, New Jersey, Ohio, Oregon and Vermont. Each State represents a wide range of geographic and demographic diversity. In addition, each of these State's program is characterized by a flexible, customer-focused orientation that addresses each State's unique needs and program objectives.

Additionally, our experience delivering effective health management and wellness programs to state Medicaid contracts affords us a distinct advantage in serving commercial state customers like the State as they support similar populations with regard to health status. According to the Kaiser Family Health Foundation, 25% of Tennessee's population is on Medicaid and it is likely that a number of State employees have dependents on Medicaid. Given this, APS can leverage our Medicaid experience and proven strategies in outreach and engagement to ensure we touch all of our members with preventive health information and engage members across the continuum of healthcare services (lifestyle management, disease management and case management) so that they can commit to the State's "partnership promise" and improve their health.

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## Quality Management Program

APS also has a fully established Quality Management Program in place to ensure our program services meet established benchmarks and standards, and that we continually improve operational processes to enhance program operations and focus program management to achieve program goals. APS incorporates the principles of quality assurance (QA) and continuous quality improvement (QI) into each activity and program that we undertake. To materially impact system performance, both internally and externally, a quality improvement perspective must be incorporated into every aspect of operations, from accurate report submission to consumer satisfaction. This approach unites members, families, providers, our customers, and APS in an integrated effort to verify and improve system outcomes.

APS repeatedly demonstrates the success of our Quality Management Program on state contracts. For example, on our Hawaii contract, we have reached the 75<sup>th</sup> HEDIS percentile on compliance with outpatient appointments within seven days after mental health hospitalization, and are steadily moving closer to reaching our goal of the 90<sup>th</sup> percentile. Similarly, APS is showing quality success in diabetes management within the State of Ohio's employee population; we have moved from the 10<sup>th</sup> to the 50<sup>th</sup> percentile for HEDIS CDC/annual HgbA1c testing in 18 months. Additional quality improvement projects are underway in Maryland, Oklahoma, Wisconsin, Georgia, and Missouri.

APS believes leadership and planning are essential to successful implementation of a QI process. Our Corporate QI Department ensures that all program operations are based on solid continuous quality improvement methodologies that underlie each program's Quality Assurance Program (QAP). As formal quality improvement is an ongoing process of thoughtful observation, analysis and corrective action, we use the Institute of Healthcare Improvement approach of rapid cycle "Plan-Do-Check-Act" (PDCA) as the conceptual framework of our overall QAP. We use the PDCA approach as it embodies our values of collaboration, discussion and action.

Our QAP process is designed to systematically monitor and evaluate the adequacy and appropriateness of services and pursue opportunities to improve health outcomes, reduce the utilization of healthcare resource, and improve consumer, provider and customer satisfaction. To support this commitment, APS maintains a QI Program with oversight by our Corporate Quality Improvement Committee (CQIC). At the corporate level, key activities for quality include annual corporate goal setting in measurable terms. Annual strategic goals for quality improvement are set in relation to four key categories: a) clinical quality; b) customer satisfaction; c) core business processes; and d) healthcare utilization. These metrics are compared to external benchmarks, meet the business goals of the organization, and are shared with the local sites. All quality monitoring and prioritized QI initiatives are related to our annual corporate goals and require the oversight of the Executive Quality Improvement Committee

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(EQIC).

To promote the procurement of quality services, APS will establish a Quality Assurance Program (QAP) to ensure that the State's Health Management & Wellness Program's policies and procedures are being successfully fulfilled in accordance with the contract. Your program-specific QAP will detail systematic, quality-focused activities used to monitor and evaluate the services we deliver to members according to predetermined, objective standards as well as the implementation of corrective actions when performance does not meet expectations. Our QAPs provide a defined system for collection, review, and analyses of program data and performance. This process begins with effective planning involving a collaborative effort by APS staff as well as collaboration and input from recipients and the medical delivery systems and its practitioners to identify appropriate indicators; measurement to determine the affected population, data sources, collection methods and frequency of data collection; data assessment to transform objective measures of processes and outcomes into meaningful information about performance; and intervention and follow-up (e.g., scope and severity of the issue; action to be taken; expectations for change; the staff responsible and timeline; and the anticipated date for interim and follow-up reports on the intervention's effectiveness).

## **Industry Recognition, Accreditation & Awards**

The quality of APS and our affiliates' programs is reflected in the accreditations we've received from URAC as we are fully accredited for Population Health Management, Disease Management and Case Management. The overall benefit of our accredited status to our clients, like the State, is demonstrated in the effectiveness of our programs at creating meaningful improvement in the lives of the members we serve, managing cost for our clients, and working with providers to advance the use of evidence in daily practice. Our staff, tools, and processes ensure that technical assistance, clear milestones of success, and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. We have taken some initial assessment steps already to determine our plan of requirements for this accreditation. We have approval to apply this process and resources to achieving NCQA accreditation for our Tennessee Service Center should we be awarded this business. APS will continue our focus on accreditation by committing to obtain NCQA and URAC accreditation as required in Contract Sections A.13.h. and A.13.i. and referenced in Contract Section A.22 of the State's RFP.

Additionally, we have been the recipient of multiple Disease Management Association of America (DMAA) awards as detailed in **Question B.23** below. Given our focus on developing and implementing quality-driven programs – many of which have been recognized by the industry – we have the infrastructure and proven success to administer the State's Health Management & Wellness program.

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**B.12. Provide a narrative description of the proposed project team, its members, and organizational structure along with an organizational chart identifying the key people who will be assigned to accomplish the work required by this RFP, illustrating the lines of authority, and designating the individual responsible for the completion of each service component and deliverable of the RFP.**

## The State's Project Team

The State's proposed project team will consist of a seasoned team of local professionals with executive oversight and support from our corporate resources to accomplish all service components and deliverables of the State's RFP. APS' approach, which we've used in 26 other states, involves establishing a Tennessee Service Center. This service center will be staffed with qualified individuals from the local community who will be hired upon contract award, and fully dedicated to serving the State's Program. APS plans on building staffing for the State's Program that will ensure all wellness/lifestyle management, disease management and case management services are conducted by highly qualified individuals who meet both APS' own rigorous internal standards as well as the State's requirements and approval. All staff will be trained on the Program's specific components. We will focus our recruitment efforts on hiring local Tennessee talent. Individuals will be hired based upon their industry experience, their skill sets relevant to their specific positions, their understanding of the State of Tennessee's local communities and culture – from the Great Smoky Mountains to the banks of the Mississippi River – as well as their shared commitment to the State's mission and objectives. Our goal is to ensure that your members are served by seasoned and knowledgeable staff who truly understands your memberships' needs and the State's Program.

Our local service center approach has been successfully employed for many of our state contracts as it allows APS' key management and staff to have daily contact with state officials and providers; it allows for the exchange of ideas, collaboration, and problem solving for member and provider-specific concerns; and it facilitates collaboration and coordination through formal as well as informal meetings. This approach also results in excellent staff morale, a shared mission of positive outcomes, and quality care for members – the end result is a program that demonstrates clinical excellence and sound fiscal results.

As many of the program's team will be hired upon contract award, APS will leverage the experience and knowledge of our existing resources from across the county to ensure the State's program receives the attention it needs for an effective program launch as well as ongoing oversight from our executive team. These individuals have a proven track record of successfully implementing and operating health management programs across the county, and will be invaluable members of the State's Project Team. The State's Project Team will include:

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- **David Glazer, Senior Vice President for Operations in the Eastern Region**, will provide executive level oversight of the State's Program.
- **Wendy Lanski, Director of Implementation**, will be responsible for overseeing the successful implementation of the State's program.
- **Megan Cormier, Vice President, Clinical Product Development**, will be responsible for providing consultation regarding the clinical design of the State's program.
- **Chelmer Barrow, D.O, Medical Director of the Missouri Service Center**, will act as the Medical Director to the State's program during the implementation phase and be responsible for providing clinical guidance and feedback regarding the program's development.
- **Erik Goetz, MBA, Vice President of Analytic Development**, will be responsible for overseeing the analytics component of the State's program.
- **Michelle Beadle, Vice President, Analytic Services**, will be responsible for coordinating the analytics analyses for the State's program.
- **Greg Flanagan, Chief Information Officer**, who is based in Nashville, will act as the APS Executive Sponsor and also be responsible for overseeing all aspects of IT for the State's program.
- **Amir Segev, Vice President of Applications Development**, will be responsible for ensuring all components of our management information system, APS CareConnection, as well as reports meet the State's requirements.
- **Julie Smith, Director of Information Technology (IT) Field Support**, will be responsible for working with Mr. Segev to ensure all components of our APS CareConnection meet the program's requirements. Ms. Smith will act as the State's designated IT Director/Manager during the implementation phase and 60 days post implementation.
- **Gordon Rothrock, Senior Vice President of Finance**, will be responsible for ensuring all financial components and processes are in place for the State's program.
- **Kristen Kunkler-Chang, Senior Recruiter**, will oversee and coordinate the hiring of program staff for the State's Health Management & Wellness Program.

At the local level, the State's Project Team who will be housed in our Tennessee Service Center will be comprised of:

- A dedicated Account Manager who will have executive oversight of the program and act as the "face" of the program to the State. This individual will report directly to Mr. Glazer.
- A designated Project Coordinator who will provide back-up to the State's Account Manager.
- A dedicated team of Lifestyle Management (LM) Health Coaches, Health Coaches, Case Managers, Health Educators, Health Promotion Coordinators and Member Service Representatives who will receive State-specific training on the program's scope of

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services, policies and procedures, protocols, performance standards and overall program expectations.

- A Medical Director who will provide leadership, oversight and consultation to the State's clinical team and provider healthcare community, ensuring that medical and clinical management components of the State's program are in compliance with the terms of the State's requirements.
- An Operations Manager who will oversee the program's operations and supervise our team of LM Health Coaches, DM Health Coaches, Case Managers, Health Educators and Health Promotion Coordinators.
- A team of Provider Liaisons who will conduct field-based training to providers on APS CareConnection, our HIPAA-compliant, web-based health management system.
- A Quality Improvement Nurse who will oversee the quality functions of the program (e.g., satisfaction surveys, complaints, etc.).
- A Member Services Manager who will oversee the call center operations and supervise the Member Services Representatives. The Member Services Supervisor will also act as your designated "Client Service Liaison" to respond to specific member-related issues identified by the State, and will report directly to the Account Manager.

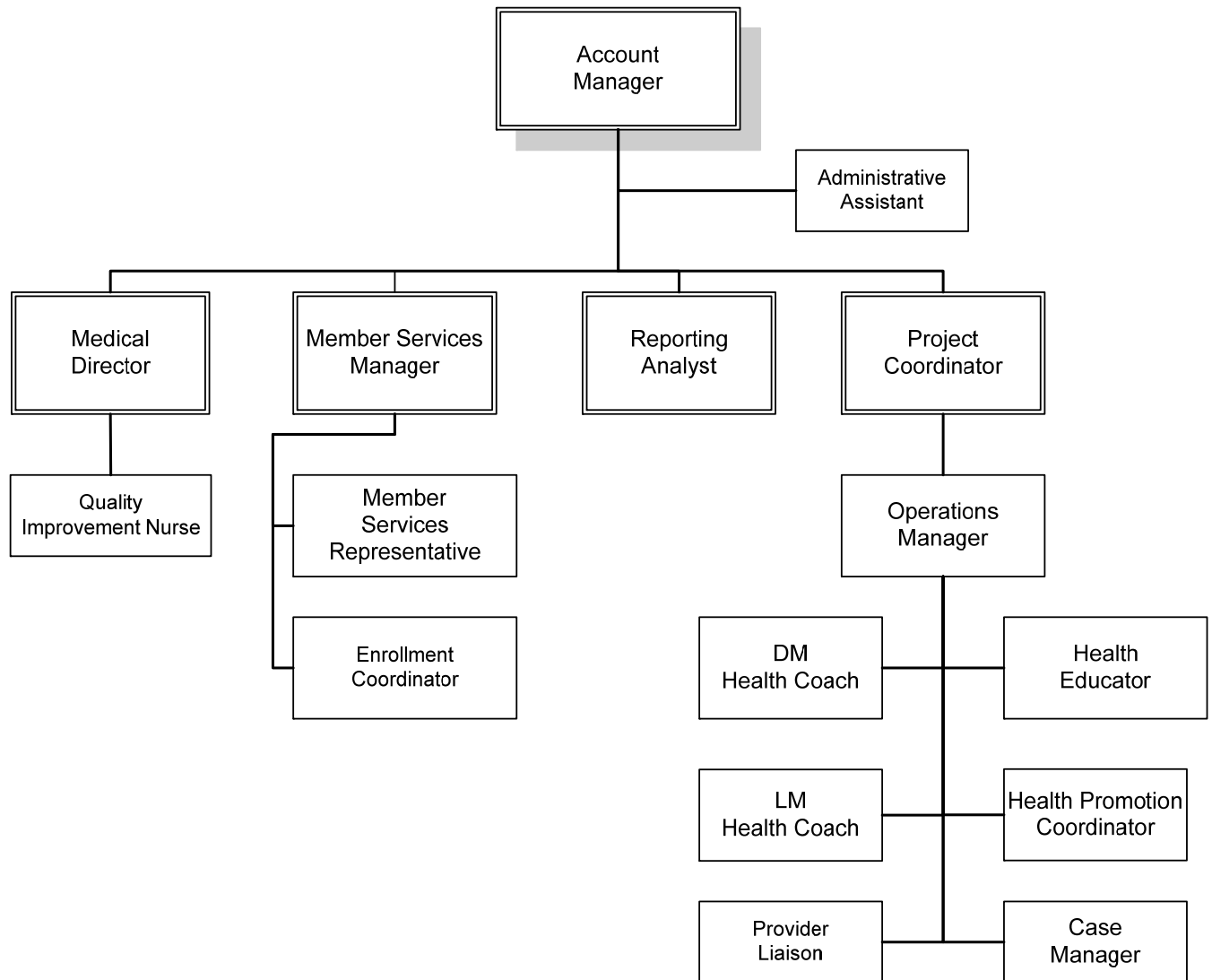
An organizational chart delineating the organizational structure of State's Project Team along with key staff who will be assigned to accomplish the work required by this RFP and lines of authority is provided on the following page.

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Biographies of the State's existing Project Team are also provided below.

### **David Glazer, Senior Vice President for Operations, Northern Region**

In his current role at APS, David Glazer oversees all program operations in the northern United States, including outcomes, budgets and meeting all contract deliverables. Previously, David oversaw all operations for APS' public sector behavioral health and disease management programs. An experienced senior executive, he has a comprehensive background in finance and resource allocation, senior staff recruitment and team building, and managing new and existing programs in government, non-profit and for-profit sectors.

Prior to joining APS, Mr. Glazer worked at ValueOptions, a national mental health managed care company. As Regional Vice President, he was responsible for several health plan division offices across the country and led the implementation and management of ValueOptions' largest national client. Serving as Vice President of Service Center Operations in New York City, he consolidated and restructured New York offices, implemented new technology systems, and recruited a new management team.

As a Vice President of Network Management at Magellan Behavioral Health, a national mental health managed care company formed by the merger of four of the largest behavioral health managed care companies, Mr. Glazer was responsible for network management for the Mid-Atlantic, Northeast, and Midwest books-of-business covering over 33 million people in a 16 state geographic area.

Mr. Glazer also served as President and Chief Executive Officer of the Postgraduate Center for Mental Health—a multi-site, non-profit mental health service organization and training institute. As Executive Director of New Medico of Long Island, he was responsible for opening outpatient operations and planning for inpatient rehabilitation services for head injured people in New York.

Mr. Glazer spent eight years working for both federal and state government. He held several positions at New York State Office of Mental Health. As Section Chief for the Community Support Program at the National Institute of Mental Health (NIMH), he served as a liaison between NIMH and the New York State Office of Mental Health through the Intergovernmental Personnel Act, a program that allowed for the occasional loan of key executives between state and federal operations.

Mr. Glazer has a master's degree in healthcare administration and a bachelor's degree in biology, both from the State University of New York at Stony Brook. He has served on several boards, including the Alliance for the Mentally Ill/NYC, Manhattan Mental Health Council and the Murray Hill Mental Health Advisory Committee.

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## **Wendy Lanski, Director of Implementation**

Wendy Lanski brings 20 years of experience in operations, vendor and project management for both profit and non-profit companies. She is highly skilled in developing and implementing large scale projects and initiatives while working effectively across all levels of an organization. As Director of Implementation, Ms. Lanski is responsible for oversight of APS's implementation activities including strategic planning, directing, tracking, monitoring and documenting all implementation aspects and phases. This includes serving as the direct client contact for multimillion dollar accounts such as the States of California and Iowa.

Prior to coming to APS, Ms. Lanski was the Director of Vendor and Institutional Relations for Affinity Health Plan. In this role, she was responsible for managing complex relationships with large institutional providers and Federally Qualified Health Centers; directing the planning, design, development, implementation and evaluation of policies and procedures to ensure effective oversight of delegated activities to contracted vendors; developing, leading and directing Joint Operating Committee (JOC) activities to enhance mutually beneficial relationships with institutional partners and to identify areas of mutual benefit (e.g., service delivery, quality, use of utilization data, clinical programs, leveraging technology); and collaborating with senior Management team on strategies to grow member and provider enrollment and increase provider satisfaction. While at Affinity, Ms. Lanski was also the Enterprise Project Manager to Affinity's Chief Operating Officer where she implemented new Medicare Advantage products; created complex implementation and project plans; developed a pharmacy transition strategy and managed its implementation; and led a number of initiatives to enhance provider community relationships.

Additionally, Ms. Lanski brings years of project planning and implementation experience through her tenure at other leading healthcare and consultant organizations. This includes a number of implementation-focused positions at Empire Blue Cross Blue Shield such as Senior Project Manager of Health Services as well as HIPAA Compliance and EDI where she led a large-scale multi-level Personal Health Record project; directed multi-level project teams including Information Technologies and Operations; and validated quality control measures and implemented process improvements. She also acted as a Senior Consultant & Vendor Manager and Manager for PriceWaterhouseCoopers's Health & Welfare Division where she created and implemented complex premium reporting processes; managed vendor relationships, developed project plans; and managed new vendor implementations.

Ms. Lanski received her Bachelor's of Science from St. Joseph's College (New York) in Organizational Management and her Master's Degree in Management from Thomas Edison State College.

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**Megan Cormier, Vice President, Clinical Product Development**  
***(Former Executive Director of the Wyoming Healthy Together! Total Population Health Management Program)***

Ms. Cormier is responsible for identifying trends in health care to recognize large and common health issues and solutions for complex, costly patient populations. Her work encompasses research on current guidelines, standards and care practices to identify opportunities to change behavior and improve outcomes. Ms. Cormier engages national and local thought leaders to shape interventions and design and test new clinical products under development at APS.

Previous to her current position, Ms. Cormier served as Executive Director of the Wyoming Total Population Health Management Medicaid Program for APS. As such, Ms. Cormier was responsible for providing comprehensive disease management (CAD, CHF, DM, COPD, Asthma, High Risk Maternity, and Depression), complex case management and Peer Review services including / pre-authorizations for care. She also oversaw utilization management, peer review, case management and quality assurance services for medical and behavioral health, including substance abuse. She was also responsible for providing wellness and prevention programs and education for all Wyoming Medicaid recipients, working in partnership with a full spectrum of Wyoming Public Health and Human Services officials and programs.

Megan first joined APS as a Marketing and Outreach Coordinator for the Wyoming Medicaid program where she coordinated the development and presentation of APS' image within State of Wyoming. She then became Director of Development for APS Public Programs, leading development efforts for the western U.S.

Ms. Cormier has ten years of experience in communications and marketing, predominantly in the healthcare industry. She has a comprehensive understanding of healthcare based on working with stakeholders along every step of the healthcare continuum: from physicians, consumers, patients and hospitals to Fortune 500 hi-tech healthcare corporations, national media, state agencies and legislators. Formerly trained as a nurse and a journalist, Megan has expertise in such areas as media relations, communication/marketing program development, advertising, hi-tech healthcare PR, healthcare economics and policy, public health outreach and education.

Prior to joining APS, Megan served as the Media Relations Director for the Massachusetts Medical Society, a Healthcare Account Manager at Sterling Hager Public Relations in Boston, the Marketing and Communications Director for a regional medical day spa, an ER nurse and as a reporter for several Wyoming newspapers.

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### **Chelmer Barrow, DO, FACP, Medical Director, Missouri Service Center**

Chelmer L. Barrow, Jr., DO, FACP serves as Medical Director for the Missouri Division of Medical Services/APS Chronic Care Improvement Program (CCIP). Dr. Barrow has been with APS since the summer of 2006. His responsibilities include oversight of the clinical aspects of the Missouri Medicaid Chronic Care Improvement Program (CCIP), coordination of care for CCIP participants, and the development of standardized treatment guidelines.

He is also a member of the Internal Medicine Department at the University of Missouri Hospital in Columbia, where he maintains an active clinical practice and is also a member of the faculty at the University of Missouri School of Medicine, where he is engaged in teaching medical students and residents.

Dr. Barrow is a graduate of the Kirksville College of Osteopathic Medicine in Kirksville, Missouri, and subsequently served a general rotating internship at Capital Region Medical Center in Jefferson City, Missouri. He then served a three-year residency in Internal Medicine at the Cleveland Clinic Foundation in Cleveland, Ohio, an international tertiary referral center. While in Cleveland, Dr. Barrow was named Resident of the Year and earned the Cleveland Clinic's "Distinguished Teacher of Medicine Award."

His clinical career has also included service as a faculty and staff member in the Internal Medicine Departments at Washington University School of Medicine, Barnes-Jewish Hospital, and St. Louis University School of Medicine in St. Louis, as well as the University of Missouri Hospital and School of Medicine in Columbia.

In 1994, Dr. Barrow was named Medical Director of GenAmerica Corporation, a St. Louis-based Fortune 500 company that provided medical management services for employees and dependents of many of the nation's largest companies including Southwest Airlines, Boeing, McDonnell Douglas, Anheuser Busch, Mr. Coffee and Toshiba Electronics. GenAmerica was also the Missouri Medicare part B carrier and provided care management services to GenCare/United, the largest HMO in Missouri. Under his direction, GenAmerica developed and expanded clinical programs in care management, utilization management, home health care, bone marrow/solid organ transplants, and disease management for over one million plan participants.

Dr. Barrow is board certified by the American Board of Internal Medicine. His honors and awards include Fellowship in the American College of Physicians (FACP), Sigma Zeta national honorary science society, Sigma Sigma Phi national medical honor society, and Who's Who in Medical Sciences Education. In 2005, he was named the University of Missouri's "Quality Improvement Champion" for his research work in diabetes care.

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## **Michelle Beadle, Vice President, Analytic Services**

Michelle Beadle brings close to 15 years of healthcare analytics experience to the State's program. She has a proven track record of superb project and operational management within APS. Her hands-on leadership style and advanced technical skills have helped ensure that APS' analytic practices meet and exceed our clients' expectations. As Vice President, Analytic Services, Ms. Beadle leads the effort to provide each customer with insightful and actionable information and recommendations to enhance performance and improve client outcomes. The result of her work is consistent reporting and analysis to help the APS team and our clients achieve goals and objectives in a timely, accurate and efficient manner. She directs and coordinates the functions of consulting staff and other project members to ensure APS analytics provide actionable data that is useful both internally and externally. Prior to her role with APS, Ms. Beadle held the role of Senior Director, Medical Analytics and Affordability for AmeriChoice and Director of Medical Economics for United Behavioral Health. She holds a bachelor's degree from California State University.

## **Erik Goetz, MBA, Vice President of Analytic Development**

Erik Goetz is a Vice President in the Health Intelligence Division of APS. He has been with the company for more than 14 years. Mr. Goetz is currently accountable for analytic support of product and new business development. Mr. Goetz oversees the production of accurate information on health care cost, utilization, and quality for potential commercial clients and state Medicaid programs. This includes performing statistical analyses on healthcare data; applying case-mix adjustment methodology for provider profiling and preparing in depth analyses on health care utilization trends and forecasts. Mr. Goetz presents information to healthcare executives, clinical, quality and finance staff and makes recommendations for program development and the measurement of quality, utilization, and financial performance.

Mr. Goetz has worked in health care administration and data analytics since 1991. He has experience working with commercial and public healthcare payers including Medicaid and CHAMPUS/TRICARE. His work background includes experience with claims adjudication, administrative and financial audit, statistical analysis and public healthcare policy. He holds a B.S. in Economics and Statistics from the University of Wisconsin at Madison and MBA from the University of Wisconsin at Whitewater.

## **Greg Flanagan, Chief Information Officer**

Greg Flanagan is responsible for Information Technology (IT) at APS. He is a Nashville, Tennessee resident and will serve as the APS Executive Sponsor to the State of Tennessee Program. He oversees all aspects of IT for the company, including strategy, architecture, applications, infrastructure, security, reporting and support. He has more than 20 years of business experience in healthcare IT management.

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Prior to joining APS in December 2007, Greg served as Chief Information Officer for a healthcare provider based in Nashville. Greg also served as President of InfoAdvantage, a Nashville-based IT business consulting services firm. InfoAdvantage offered IT outsourcing, project management, software/Web development and IT infrastructure services to its members. Earlier in his career, Greg was Vice President of Theraphysics Corporation, a care management firm specializing in physical medicine and rehabilitation.

Greg is a member of the Healthcare Information Management Systems Society and volunteer regional director for The Miami Project to Cure Paralysis. He earned a bachelor's degree in economics and a master's degree in hospital administration from Duke University.

### **Amir Segev, Vice President, Application Development**

Amir Segev is Vice President of Application Development for APS. He has leadership responsibility for business analysis, application planning, enterprise architecture, and software development and implementation, supporting care coordination and delivery via member-centric technology solutions. Mr. Segev has over 20 years of experience in information technology with an emphasis on developing IT solutions for healthcare. Prior to joining APS, Mr. Segev worked for Merck-Medco, Cigna Healthcare and CareFirst BCBS in various leadership roles. He holds a B.S. in Computer Science/Business Administration from Ramapo College in New Jersey and is a Certified Computer Engineer through the Israeli Defense Force Computer Academy.

### **Julie Smith, Director of Information Technology (IT) Field Support**

Julie Smith is responsible for developing and implementing daily business processes for new APS programs. In this capacity, she assesses technology needs for new program implementations, and monitors and guides the process of aligning resources and functionality to optimize IT utilization across APS offices and client locations. Additionally, she customizes APS' proprietary, HIPPA compliant, web-based care management tool, APS CareConnection® to meet specific client needs and state and federal regulations.

Ms. Smith has over 20 years of progressively responsible experience in provider and managed healthcare arenas. Most recently, Ms. Smith served as the Director of Training and Field Development for the Public Programs division of APS Healthcare. Previously, Ms. Smith served as the Fiscal Compliance Liaison for APS' Maryland Medicaid and Uninsured Administrative Services contract. Ms. Smith has participated in the successful implementation of 12 new contracts utilizing customized APS CareConnection® applications. She was pivotal in the implementation of a web based authorization system for the State of Maryland's mental health program. She served as the Director of Operations for APS' TRICARE Region 2/5 contract, overseeing daily administrative operations, including a 24/7 call center servicing beneficiaries accessing mental health benefits. She developed and implemented staffing patterns for a

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customer service line that handled an average of 3000 calls per week.

Before joining APS, Ms. Smith participated in the successful implementation of five TRICARE contracts. Her duties included creating provider communications, developing policies and procedures, coordinating claims software and performing IT functions. As Director of Provider Enrollment for the Corporate Network Development Department at ValueOptions, she managed units responsible for credentialing, re-credentialing and file maintenance of practitioners, organizations and facilities to NCQA standards.

### **Gordon Rothrock, Senior Vice President, Finance**

As Senior Vice President of Finance, Gordon Rothrock oversees all of APS financial functions, including budgets, forecasts, financial reporting and pricing review. Mr. Rothrock previously served as Vice President, Corporate Controller for APS.

Prior to joining APS in 2005, Mr. Rothrock worked as a consultant with Robert Half Management Resources, the world's largest provider of senior-level finance professional in Huffman Estates, Illinois, where he worked with European and U.S.-based companies.

Additionally, Mr. Rothrock taught business courses for senior-level managers for AEON Corporation, a leading English language school, in Chiba and Kawasaki, Japan. He worked as a controller for DSC Logistic in Des Plaines, Illinois, and FMC Corporation in Chicago.

Mr. Rothrock also served as Senior Vice President, Controller for ValueOptions, where he was responsible for corporate-wide budgeting, accounting, billing, contract compliance and claims reserve analysis.

Earlier in his career, Mr. Rothrock was an accountant for Arthur Young & Company, which is now part of Ernst & Young LLP.

Mr. Rothrock received a bachelor's degree in English, with a minor in French, from Occidental College in Los Angeles. He earned a Master of Business Administration degree, with a concentration in Corporate Finance and Accounting, from University of Southern California in Los Angeles.

### **Kristen Kunkler-Chang, Senior Recruiter**

Kristen Kunkler-Chang partners with executives throughout APS to find and secure talent to build customized teams to service APS clients. She recruits for all healthcare positions in our field locations in addition to executive-level Information Technology, Finance, Health Intelligence, and Account Management positions. Prior to her position with APS, Ms. Kunkler-Chang was a Senior Recruiting Consultant for Elite Human Capital Group (recently

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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merged with C&C Recruiting and Consulting), a Senior Recruiter/Staffing Manager at RedPrairie Corporation, and a Senior Recruiter at Advanced Healthcare. She has a bachelor's degree from the University of Wisconsin-Milwaukee.

The following individuals will also provide consultation and guidance to the State's Health Management & Wellness Program:

**Roger D. Cone, Ph.D., Director of the Vanderbilt Institute for Obesity and Metabolism**

Roger Cone, Ph.D., Director of the Vanderbilt Institute for Obesity and Metabolism and Professor and Chairman, Molecular Physiology and Biophysics, Vanderbilt University Medical Center, brings over 22 years of experience in neuroendocrine research to this project. His research has focused specifically on central control of energy homeostasis and the common monogenic obesity syndrome which is responsible for up to 5% of severe pediatric obesity. He brings this expertise to the team in support of APS' efforts to develop effective interventions and educational materials for obesity and related disorders.

He and his team are available to consult, as needed, based on best practices in scientific literature. Mr. Cone established the Vanderbilt Institute for Obesity and Metabolism in 2008. He is currently engaged in a large scale screen for allosteric modulators of the melanocortin-4 receptor, the cause of monogenic obesity syndrome.

Prior to joining Vanderbilt, Mr. Cone served as Director of Ohio State University's Center for the Study of Weight Regulation and Associated Disorders, and as Senior Scientist for Oregon Health & Science University's Vollum Institute. He has 142 peer-reviewed publications to his credit and an impressive list of honors and awards covering the span of his career. They include an election to the National Academy of Sciences; *Donald F. Steiner Award for Outstanding Achievement in Diabetes Research*, University of Chicago; and the Bristol-Myers Squibb *Freedom to Discover Unrestricted Metabolic Research Award*, to name a few. Mr. Cone earned a Bachelor of Arts in Biochemistry from Princeton University, a Doctorate in Biology from Massachusetts Institute of Technology, and Postdoc in Virology from Cold Spring Harbor Laboratory in NY.

**Shelagh Ann Mulvaney, Ph.D., Assistant Professor, Vanderbilt University**

Shelagh Ann Mulvaney, Ph.D., has close to 15 years of experience in research design, behavioral measurement, and pediatric health psychology research directly relevant to the proposed program. Her research focuses on the use of technology (e.g. Internet and mobile technologies) to support patient health behaviors; and she has established innovative and effective interventions translated from basic behavior change theory and research.

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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Her background in pediatric psychology and program evaluation has been applied toward the design and testing of behavioral support programs; and as PI or co-investigator on several NIH-funded grants, Ms. Mulvaney has designed and implemented behavioral interventions to improve adherence in pediatric type 1 and type 2 diabetes. Her skills in measurement have been applied to the development of two behavioral measures related to identifying psychosocial barriers to behavior change, and problem-solving those barriers. Those scales are being implemented in three clinics nationally.

Prior to her current position as Assistant Professor within Vanderbilt's Division of Adolescent Medicine, Pediatrics; School of Nursing; and the Department of Biomedical Informatics, she served as research specialist and consultant for multiple universities and programs including the Department of Pediatrics, University of Arizona; Program in Pediatric Integrative Medicine, and the University of Arizona. Ms. Mulvaney brings to this project a Bachelor of Science in Bio-psychology from the University of Arizona, a Doctorate in Clinical Psychology from the University of Arizona; and Postdoc in Children's Mental Health Program Evaluation from the Vanderbilt University Peabody College.

### **David G. Schlundt, Ph.D., Associate Professor, Vanderbilt University**

David G. Schlundt, Ph.D., is an associate professor of Psychology at Vanderbilt University. He has been a member of the Diabetes Research and Training Center since 1985. He also works with the Vanderbilt Ingram Cancer Center, and the Vanderbilt Institute of Community and Translation Research as the director of the qualitative research core. Ms. Schlundt is a member of the Clinical and Translational Science Award, Community Engaged Research Core. His research has focused on social, emotional, and environmental influences on eating behavior.

This work has broadened into an interest in the effects of environmental factors on lifestyle behaviors and health disparities, the development and validation of behavioral assessment tools, and testing behavioral interventions. His current work examines how community action, public policy, and environmental change can be used to promote healthy eating and exercise. He is collaborating with the Tennessee State Department of Health to evaluate the development and implementation of a state obesity plan. Mr. Schlundt is also working with the Nashville Health department to evaluate their Communities Putting Prevention to Work grant, which will use a wide range of strategies to promote healthy eating and exercise.

Prior to his tenure with Vanderbilt University, Mr. Schlundt served as an assistant professor of psychology for the University of Mississippi, School of Medicine. He has an impressive list of 164 publications to his name and is currently involved with many National Institute of Health research studies. Mr. Schlundt earned a Bachelor of Arts in Psychology from Indiana University and a Master of Science in Clinical Psychology from the University of Wisconsin, Madison.

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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### **Kenneth A. Wallston, Ph.D., Professor, Vanderbilt University**

Kenneth A. Wallston, Ph.D., is a Professor of Psychology and the Joe B Wyatt Distinguished University Professor at Vanderbilt. Mr. Wallston is affiliated with the Kennedy Center, the Diabetes Research and Training Center, the Vanderbilt-Ingram Cancer Center, the Center for Research in AIDS, the Program in Effective Health Communication, the Vanderbilt Institute for Energy and the Environment, and the Climate Change Research Network. He is also a member of the Geriatric Research Education and Clinical Center (GRECC) at the Veterans Administration Tennessee Valley Healthcare System in Nashville.

Mr. Wallston is experienced in social psychology, health psychology/behavioral medicine, and research on environmental behaviors that affect climate change. He was one of the founders of the Vanderbilt Weight Management Program and has been the PI or Co-PI on a number of research grants related to topics in behavioral medicine.

He currently serves as Director of the Health Care Research Project, Vanderbilt School of Nursing; a member of the John F. Kennedy Center for Research on Education and Human Development, and as a behavioral scientist for Health Services Research Center for Patient Healthcare Behavior, Veterans Administration Tennessee Valley Healthcare System. He has a Bachelor of Arts in psychology from Cornell University, and a Master of Arts and Doctorate from the University of Connecticut.

### **Joan A. Randall, Assistant Professor, Vanderbilt University**

Joan A. Randall implemented the public health and policy-related initiatives of the Vanderbilt Institute for Obesity and Metabolism (VIOM). Through the VIOM, she works closely with the Vanderbilt Health and Wellness Program, as well as scientists from multiple disciplines who are focused on obesity and obesity-related diseases (molecular physiology and biophysics, genetics, medicine, cardiology, pediatrics, cancer, diabetes, surgery, psychiatry, psychology, neuro-imaging, biochemistry, cell biology, public health and biomedical informatics). She works closely with colleagues throughout Tennessee to develop and implement a comprehensive and cohesive plan to reduce the burden of obesity using systematic, multidisciplinary and evidence-based strategies.

Prior to her position with Vanderbilt Institute, Ms. Randall was a research analyst for Shaping America's Youth, a collaborative effort created by the Surgeon General to form a national action plan to address childhood and adolescent obesity. She also served as Administrative Director of the Center for the Study of Weight Regulation and Associated Disorders at the Oregon Health & Science University, enabling her to become involved in community efforts and public policy around obesity and diabetes in Oregon. Ms. Randall has a Bachelor of Arts in business from the Eastern Oregon State College and a Master's Degree in Public Health (health administration and policy, with an emphasis on childhood obesity) from Portland

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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State University.

## **Mary Nell Bryan, Tennessee Consultant**

Mary Nell Bryan brings 20 years advocacy experience and 12 years of government relations consultancy experience to this project; much of her experience and knowledge is rooted in her service to Tennessee-based organizations. Ms. Bryan's current client list includes Children's Hospitals Alliance of Tennessee – president (executive director of the alliance); TN School Health Coalition; TN Licensed Professional Counselors Association; TN School Nutrition Association; Nashville Humane Association; March of Dimes; Big Brothers Big Sisters; United Cerebral Palsy; and Bridgepoint Education Inc.

Past clients have included AstraZeneca; First Medical Management Corporation; Middle TN Mental Health Cooperative; CHART (Campaign for a Healthy and Responsible TN); TN Perinatal Association; TN Association of School Nurses; TN Association of Health Plans (coalition of TennCare MCOs and private MCOs); TN Coordinated Care Network, (parent company of second largest TennCare MCO); TN Association of Surgical Technologists; TN School Counselors Association; TN Affordable Housing Coalition; and TN Edenizing Foundation (group providing alternative elder care for those not needing nursing homes), among others.

Prior to self-employment, Ms. Bryan served as Director of Communications, Director of Government Relations for Tennessee Coordinated Care, and as Legislative Liaison for Governor Ned McWherter where she concentrated on state and local and environmental issues and troubleshooted judiciary and healthcare issues. In this position she was promoted to assistant to Governor Ned McWherter and deputy to the Governor Jim Kennedy. Additionally, she formerly served as lead lobbyist for Smith Johnson Anderson & Carr where she lobbied for TN Sheriffs' Association, Citizens for Home Rule, TN Association of Personnel Consultants, and TN Association of Mental Health Organizations.

Ms. Bryan earned a bachelor's degree from Vanderbilt University where she was recipient of the Maggie S. Craig full scholarship and the National Merit Scholarship. Ms. Bryan currently volunteers for the Board of CHART, TN Healthy Weight Network Board, and the TN Obesity Task Force. She also serves as Action for Healthy Kids Board and Legislative Chair.

**B.13. Provide a personnel roster listing the names of key people who the Proposer will assign to perform duties or services required by this RFP along with the estimated number of hours that each individual will devote to that performance. Follow the personnel roster with a resume for each of the people listed. The resumes must detail the individual's title, education, current position with the Proposer, and employment history.**

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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In developing our staffing model for the State's Program, we will utilize a combination of existing and new staff. Our proposed staffing is presented in the personnel roster below.

APS Key Personnel for the State's Program		
Name	Position	Estimated # of Hours Devoted to Program
David Glazer	Senior Vice President of Operations, Eastern Region	35% during implementation 10% during contract
Wendy Lanski	Director of Implementation	80% during implementation 0% during contract
Megan Cormier	Vice President, Clinical Product Development	30% during implementation 10% during contract
Chelmer Barrow	Medical Director	25% during implementation Replaced by hired Medical Director for contract
Michelle Beadle	Vice President, Analytic Services	25% during implementation 15% during contract
Erik Goetz	Vice President of Analytic Development	25% during implementation 0% during contract
Amir Segev	Vice President of Applications Development	10% during implementation 10% during contract
Julie Smith	Director of Information Technology Field Support	50% during implementation and 60 days post go-live
Gordon Rothrock	Senior Vice President of Finance	10% during implementation 5% during contract
Greg Flanagan	Chief Information Officer	10% during implementation 5% during contract
Kristen Kunkler-Chang	Senior Recruiter	75% implementation 0% during contract
Roger D. Cone	Professor and Chair, Vanderbilt University, Institute of Obesity and Metabolism	5% during implementation 5% during contract
Ann Shelagh Mulvaney	Assistant Professor of Nursing, Pediatrics, & Biomedical Informatics, Vanderbilt University, Institute of Obesity and Metabolism	5% during implementation 5% during contract
Joan A Randall	Assistant Professor, Vanderbilt University, Institute of Obesity and Metabolism	5% during implementation 5% during contract

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APS Key Personnel for the State's Program		
Name	Position	Estimated # of Hours Devoted to Program
David G.Schlundt	Associate Professor of Psychology, Vanderbilt University, Institute of Obesity and Metabolism	5% during implementation 5% during contract
Kenneth A. Wallston	Professor of Psychology in Nursing, Vanderbilt University, Institute of Obesity and Metabolism	5% during implementation 5% during contract
Mary Nell Bryan	Tennessee Consultant	20% during implementation 5% during first year of contract
To be hired	Account Manager	100%
To be hired	Medical Director	100%
To be hired	Project Coordinator	100%
To be hired	Operations Manager	100%
To be hired	Lifestyle Management Health Coaches	100%
To be hired	Disease Management Health Coaches	100%
To be hired	Case Managers	100%
To be hired	Health Educators	100%
To be hired	Health Promotion Coordinators	100%
To be hired	Enrollment Coordinators	100%
To be hired	Provider Liaisons	100%
To be hired	Quality Improvement Nurse	100%
To be hired	Member Services Manager	100%
To be hired	Member Services Representatives	100%
To be hired	Reporting Analyst	100%
To be hired	Administrative Assistant	100%

Resumes of existing staff are provided in **Exhibit I**. Resumes detail the individual's title, education, current position with APS and employment history. We have provided sample job descriptions in **Exhibit J** for those positions that are to be filled upon contract award.

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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**B.14. Provide a statement of whether the Proposer intends to use subcontractors to accomplish the work required by this RFP, and if so, detail:**

- (a) the names of the subcontractors along with the contact person, mailing address, telephone number, and e-mail address for each;
- (b) a description of the scope and portions of the work each subcontractor will perform;
- (c) a description of how the Proposer will monitor and evaluate subcontractor performance; and
- (d) a statement specifying that each proposed subcontractor has expressly assented to being proposed as a subcontractor in the Proposer's response to this RFP.

**Subcontractor includes any entity that will provide any administrative service for the Proposer related to fulfilling the requirements of the Contract, including but not limited to health screenings, call center and nurse advice line, lifestyle management program(s), disease management program(s), case management program(s), and member website/portal management.**

## **Subcontractor Contact Information & Services**

APS will deliver the majority of the services requested under the State's Health Management & Wellness program. However, APS will subcontract with leading specialty companies to deliver some of the services including the health questionnaire, online lifestyle management programs, onsite health screenings, and nurse line services. These subcontractors complement our own expertise in wellness/lifestyle behavior change; disease management; case management; provider outreach, engagement, integration and practice facilitation; and information technology. Specifically for the Tennessee Program, APS will partner with:

- eDoc4U for health questionnaire and online lifestyle management programs. In eDoc4U, we have identified a partner with core capabilities in online wellness, including health questionnaire and online support content, member tools, and wellness points tracker, and that happens to be headquartered in Nashville. Furthermore, eDoc4U has built partnerships with Vanderbilt as well as Meharry Medical College in Nashville, to develop a health questionnaire and videos tools, which are culturally and ethnically sensitive to maximize behavior change.

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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- Summit Health for onsite health screening services. Summit Health is equally experienced in delivering quality health screening events with over 10 years of providing worksite wellness services. Summit Health has a solid national network of more than 6,000 highly trained and proficient employees, and is the only provider to meet the regulatory requirements for on-site CLIA-waived health screenings and immunizations in all 50 states. Summit Health also offers a user-friendly online appointment scheduling system that has resulted in positive participant experiences.
- Carenet for 24/7 Nurse Line services. Carenet is a privately owned corporation (Infomedia Group, Inc.) with a 21-year track record of superior growth, performance and stability. Founded in the late 1980's by a world renowned healthcare system, Carenet delivers nurse line services and now supports more than seven (7) million members. Headquartered in San Antonio, Texas, CareNet operates a URAC accredited contact center utilizing industry-leading clinical software.
- Vanderbilt Institute for Obesity and Metabolism (Vanderbilt) for advisory and consultation services regarding our Morbid Obesity Program. Vanderbilt has extensive experience researching the treatment and prevention of obesity including the environmental, cognitive and emotional factors that influence behavioral strategies regarding obesity treatment as well as obesity's health disparities and how to best engage the community in obesity programs – all of which we believe will assist APS in enhancing our engagement, intervention and education strategies with members who are at risk or already obese.

To ensure transparency to members and function as a unified force with a shared focus – the member's health and well-being, APS will act as the State's Prime Integrator. As the Prime Integrator, we coordinate with our subcontractor partners using proven service integration protocols to establish multi-service programs that are seamless to members, result in simplified program management for our customers, and result in the most holistic and coordinated care possible for members. This includes establishing effective and efficient data exchange protocols to ensure our subcontractors have access to the same clinical information and that all parties can appropriately coordinate services. This also includes establishing seamless interface protocols for cross-referrals, coordination of care issues, follow-up criteria, etc. to ensure benefits are transparent to members and that they receive the most appropriate service as quickly as possible. Furthermore, we identify liaisons with each subcontractor to clarify questions, resolve issues quickly and consult on complex/special cases. Additionally, as both eDoc4U and Vanderbilt are located in Tennessee, these entities are staffed with professionals from the local communities and will bring a unique understanding of the State's culture and challenges to our program. APS will leverage their local knowledge along with our corporate resources and talent to administer a best-in-class program for the State, delivered by

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Tennesseans who truly understand your needs.

Contact information for each subcontractor is provided below:

	<b>eDoc4U</b>	<b>Summit Health</b>
<b>Contact Person</b>	Richard Smith	Richard Penington
<b>Contact Title</b>	President	President
<b>Mailing address</b>	3212 West End Ave. Suite 500 Nashville, TN 37203	25300 Telegraph Road Suite 250 Southfield, MI 48033
<b>Telephone number</b>	615-269-5710	248-416-1602
<b>E-mail address</b>	rich@edoc4u.com	rpenington@summithealth.com

	<b>Carenet</b>	<b>Vanderbilt Institute for Obesity and Metabolism</b>
<b>Contact Person</b>	Mark Ureste	Joan Randall, MPH
<b>Contact Title</b>	Senior Director of Business Development	Administrative Director
<b>Mailing address</b>	11845 IH 10 W Suite 400 San Antonio, TX 78230	Vanderbilt University, Institute for Obesity and Metabolism Molecular Physiology and Biophysics 802 Light Hall 1161 21st Avenue South Nashville, TN 37232
<b>Telephone number</b>	210-595-2018	615-936-2909
<b>E-mail address</b>	mureste@callCarenet.com	joan.a.randall@vanderbilt.edu

### Monitoring & Evaluating Subcontractor Performance

As the State's Prime Integrator, APS will be your key contact for all questions, requests and/or issues regarding our entire spectrum of services whether provided by APS directly or our subcontractors. We monitor the performance of our each of subcontracting partners to ensure we continue to meet our customers' program requirements. As part of our agreements, service performance standards are established with each partner that clearly outline their responsibilities as well as our expectations regarding quality services (e.g., call center performance standards, website availability, turnaround times for data file exchanges, accuracy of data files, etc.). Subcontractor performance is monitored on a regular basis by senior members of the APS management team.

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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## **Confirmation of Subcontractor Agreement to Partner**

APS confirms that Summit Health, eDoc4U, Carenet and Vanderbilt have expressly assented to being proposed as a subcontractor in our response to this RFP. Agreement letters have been provided as **Exhibit Z**.

### **B.15. Provide documentation of the Proposer's commitment to diversity as represented by its business strategy, business relationships, and workforce— this documentation should detail all of the following:**

**(a) a description of the Proposer's existing programs and procedures designed to encourage and foster commerce with business enterprises owned by minorities, women, persons with a disability and small business enterprises;**

APS is fully committed to diversity with regard to our business strategy, business relationships and workforce. While APS does not have a formal supplier diversity program, we are committed to ensuring the highest standards of social responsibility in everything we do. As a part of our ongoing commitment, our objective is to work with business enterprises owned by minorities, women, persons with a disability and small business enterprises. We actively seek out and work with such suppliers and clearly understand the benefits that come from working with locally-owned businesses in the communities in which we provide services. Through serving 53 government entities, we are well-versed in establishing partnerships with business enterprises owned by minorities, women, persons with a disability and small business enterprises as it is mandated by many of our government contracts. To successfully provide services, our programming and delivery must reflect the diversity of our clients and their members. As such, an integral part of our delivery model is to purchase services and materials from a supplier base representative of our customers, their members and the community.

APS' subcontractors are also committed to working with minority and women business owned enterprises. For example, from 2005-2006, our partner, eDoc4U, collaborated with Meharry Medical College, which is one of the five predominantly African American Medical Colleges in the United States, as part of a \$2.5M grant that the college received from the Department of Health and Human Services to build out the African American cultural competence of eDoc4U's services.

Additionally, APS believes a diverse workforce enhances our ability to provide excellent customer service. All of our employees are aware of this commitment and fully support its objectives by demonstrating respect for, and valuing, the differences which enable each of us to be an important contributor to APS' business efforts. We also are committed to the principles and objectives of Equal Employment Opportunity and Affirmative Action and compliance with all applicable laws and regulations. Our policy is to provide equal employment

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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and advancement opportunities to everyone, basing employment decisions on merit, qualifications, and abilities, and ensuring employment practices are neither influenced nor affected by an applicant's or employee's race, color, religion, sex/gender, national origin, age, disability, or any other characteristic protected by law. Furthermore, our Equal Opportunity Policy makes reasonable accommodations for qualified individuals with known disabilities unless doing so would result in undue hardship. Lastly, we are dedicated to a work environment that is free of discrimination and harassment, and has a discrimination and harassment policy that strictly forbids sexual, ethnic or other harassment whether verbal, physical or environmental.

**(b) a listing of the Proposer's current contracts with business enterprises owned by minorities, women, persons with a disability and small business enterprises, including the following information:**

**(i) contract description and total value**

**(ii) contractor name and ownership characteristics (i.e., ethnicity, sex, disability)**

**(iii) contractor contact and telephone number;**

APS has provided the requested information regarding our current contracts with business enterprises owned by minorities, women, persons with a disability as well as small business enterprises in the table below. Please note the total value of these contracts is \$3,569,123.

Contract Description	Contractor Name	Ownership Characteristics	Contractor Contact & Telephone Number
Provides printing services	Brenneman Printing Industries Inc.	Woman Business Enterprise	John Del Valle 717-299-2847
Provides computer programming services	Zeomega	Minority Business Enterprise	Shannon Hook 214-618-9880 x8021
Provides counseling services	Universal Counseling Services, Inc.	Minority Business Enterprise	Tracy Schulden 410-752-5525
Provides development and consulting services	Software Consortium	Woman Business Enterprise	Patrick Roger 410-583-9393
Provides office furniture and supplies	*Select Business Products	Minority Business Enterprise	Ken Reed 877-696-7266
Provides consulting services	Dockside Solutions Inc	Minority Business Enterprise	Sandy Smolnick 410-263-3179
Provides office furniture and supplies	**Metro Office Solutions	Minority Business Enterprise	Ken Reed 877-696-7266
Provides IT Support and Provider field support	Adept Consulting	Minority Business Enterprise	Susan Quigley 717-691-0167

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Contract Description	Contractor Name	Ownership Characteristics	Contractor Contact & Telephone Number
Acts as a Regional Advisory Committee Consultant. Provides data entry and administrative support	Black Consulting Services, Inc.	Woman Business Enterprise	Ruthann Black 717-620-3042
Provides desk top support and HEDIS Nurses	BT Consulting, LLC	Minority Business Enterprise	Byron Hutchinson 717-799-5832
Provides NeoNatalCare services	ProgenyHealth	Woman Business Enterprise	Ellen Strang 610-832-2001
Provides IT equipment	Hi-Tech Laser Systems	Woman Business Enterprise	Sharon Giovanni 610-759-1240

\*As of 4/29/2010, APS is required to report Select Business Solutions as our MBE although we no longer do business with them.

\*\*The relationship between this MBE (in place of Select Business) and APS has yet to be approved by the customer.

**(c) an estimate of the level of participation by business enterprises owned by minorities, women, persons with a disability and small business enterprises in a contract awarded to the Proposer pursuant to this RFP, including the following information:**

- (i) participation estimate (expressed as a percent of the total contract value that will be dedicated to business with subcontractors and supply contractors having such ownership characteristics  
— PERCENTAGES ONLY — DO NOT INCLUDE DOLLAR AMOUNTS)**
- (ii) descriptions of anticipated contracts**
- (iii) names and ownership characteristics (i.e., ethnicity, sex, disability) of anticipated subcontractors and supply contractors anticipated; and**

## Participation Level

APS estimates that we will provide 2-3% of the total contract value towards services purchased through enterprises owned by minorities, women, persons with a disability and/or small business enterprises.

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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## **Anticipated Contracts**

APS anticipates the following services will be contracted for the State's Health Management & Wellness Program:

- Graphic design and writing assistance for health promotional materials
- Printing services
- Office supplies
- Permanent staffing/recruitment services for professional, IT, administrative and healthcare staff, including RNs
- Translation of health promotional materials.

## **Names & Ownership Characteristics**

APS has reached out to the following Tennessee-based minority/women/persons with disability and small business enterprises to determine their interest in working with APS on the State's Health Management & Wellness program:

Graphic design/marketing/writing:

- D.G. Stanley Graphics, WBE, Franklin
- Hispanic Marketing Group, LLC, MBE, Nashville
- Kenesaw Marketing, Inc., MBE, Knoxville
- Lovell Communication, Inc., WBE, Nashville
- New Century Group, dba Designsensory, SBE, Knoxville
- The Bingham Group, WBE, Knoxville
- Angela Foglesong dba Grafix Design Studio, WBE, White House
- Ecko Designs, WBE, Nashville
- Impact Events dba Hispanic Link Consulting, WBE, Nashville
- Auris Marketing, WBE, Nashville
- Bishop, Stein and Associates, PR, Inc., MBE, Mt. Juliet
- Cassel International, MBE, Hendersonville
- Crigital Media, Inc., WBE, Mt. Juliet
- Directfx Solutions, MBE, Memphis
- KS and Associates dba DK Brand Strategy, WBE, Nashville
- Hamman Marketing Associates, SBE, Johnson City
- The Redwing Group, MBE, Memphis

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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## **Printing:**

- All Girl Press, LLC, WBE, Nashville
- Broadwater and Associates Group, Inc., MBE, Nashville
- Burns Mailing and Printing, Inc., SBE, Knoxville
- Business Ink, Company, WBE, Memphis
- Golden Circle Printing, Inc., SBE, Jackson
- Memphis Digital Graphics, WBE, Bartlett
- Smyrna Graphics, WBE, Nashville

## **Office Supplies:**

- Amtav, LLC, WBE, Murfreesboro
- Bentco Office Solutions, MBE, Chattanooga
- International Office Products, Inc., WBE, Nashville
- Office Machines and Supply Company, Inc., SBE, Bristol
- Ron Ford's Office Supply Co., Inc.

## **Staffing (IT):**

- Alexander Consulting Services, LLC, WBE, Chattanooga
- AllTech, Inc, MBE, Memphis
- Conch Technologies, Inc., MBE, Memphis
- Zycron, Inc., MBE, Nashville

## **Staffing (Medical/Nursing):**

- OR Nurses, Inc., WBE, Germantown
- SA Occupational, MBE, Medon
- Staffing Partners, MBE, Nashville
- Nursing Resource Solutions, LLC, MBE, Nashville
- Omni Health Management, MBE, Hendersonville

## **Staffing (General):**

- Arvie Personnel Services, LLC, MBE, Nashville

## **Translation:**

- Robledo Translations, LLC, WBE, Knoxville
- Your Spanish Link, LLC, MBE, Clarksville
- Global Translation Services, MBE, Nashville
- Open Communications International, Inc., MBE, Nashville
- P and L Translations, LLC, WBE, Nashville
- ProLingua, Inc., WBE, Nashville

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**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

**RFP No. 31786-00105**

We have received interest from the following minority/women/persons with disability and small business enterprises and have identified them as candidates to provide the services listed above for the State's Health Management & Wellness Program:

Company Name	Services	Ownership	Location
D.G. Stanley Graphics	Graphic Design	Woman Business Enterprise	Franklin
New Century Group dba Designsensory	Graphic Design	Small Business Enterprise	Knoxville
The Bingham Group	Graphic Design	Woman Business Enterprise	Knoxville
Cassel International	Graphic Design/Marketing	Minority Business Enterprise	Hendersonville
Auris Marketing	Communications (satisfaction surveys)	Woman Business Enterprise	Nashville
All Girl Press, LLC	Printing	Woman Business Enterprise	Nashville
Broadwater and Associates Group, Inc.	Printing	Minority Business Enterprise	Nashville
Burns Mailing and Printing	Printing	Small Business Enterprise	Knoxville
Bentco Office Solutions	Office Supplies	Minority Business Enterprise	Chattanooga
International Office Products, Inc. (EZIOP)	Office Supplies	Woman Business Enterprise	Nashville
Alexander Consulting Services, LLC	IT Staffing	Woman Business Enterprise	Chattanooga
S. A. Occupational Consulting, LLC	Medical/Nurse Staffing	Minority Business Enterprise	Medon
Nursing Resources Solutions, LLC	Medical/Nurse Staffing	Minority Business Enterprise	Nashville

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

Company Name	Services	Ownership	Location
Omni Health Management, Inc.	Medical Staffing	Minority Business Enterprise	Hendersonville
O.R. Nurses, Inc.	Medical Staffing	Woman Business Enterprise	Germantown
Robledo Translations, LLC	Translation (Spanish)	Woman Business Enterprise	Knoxville
Global Translation Services	Translation	Minority Business Enterprise	Nashville
P and L Translations, LLC	Translation	Woman Business Enterprise	Nashville

**(d) the percent of the Proposer's total current employees by ethnicity, sex, and disability.**

**NOTE: Proposers that demonstrate a commitment to diversity will advance State efforts to expand opportunity to do business with the State as contractors and sub-contractors. Proposal evaluations will recognize the positive qualifications and experience of a Proposer that does business with enterprises owned by minorities, women, persons with a disability and small business enterprises and that offers a diverse workforce to meet service needs.**

APS has provided the percent of our total current employees by ethnicity, sex, and disability in the following table:

<b>Female</b>	76%
<b>Male</b>	24%
<b>Disabled</b>	0.6%
<b>Non-Disabled</b>	99.4%
<b>American Indian</b>	0.4%
<b>Asian</b>	4.9%
<b>African American</b>	14.2%
<b>Hawaiian/Pacific Islander</b>	1.5%
<b>Hispanic/Latino</b>	19%
<b>Caucasian</b>	58.5%
<b>2 or more races</b>	1.5%

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

**B.16. Provide a statement of whether or not the Proposer has any current contracts with the State of Tennessee or has completed any contracts with the State of Tennessee within the previous 5-year period. If so, provide the following information for all of the current and completed contracts:**

- (a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract;
- (b) the procuring State agency name;
- (c) a brief description of the contract's scope of services;
- (d) the contract term; and
- (e) the contract number.

**NOTES:**

- Current or prior contracts with the State are not a prerequisite and are not required for the maximum evaluation score, and the existence of such contracts with the State will not automatically result in the addition or deduction of evaluation points.
- Each evaluator will generally consider the results of inquiries by the State regarding all contracts noted.B.1. Detail the name, e-mail address, mailing address, telephone number, and facsimile number of the person the State should contact regarding the proposal.

APS has provided the requested information for another project, the Tennessee Waiver Transition Program, which we completed with the State of Tennessee within the past five (5) years below.

<b>(a) the name, title, telephone number and e-mail address of the State contact knowledgeable about the contract;</b>	Richard Strecker, Contract Manager (615) 507-6666 richard.strecker@state.tn.us
<b>(b) the procuring State agency name;</b>	Bureau of TennCare
<b>(c) a brief description of the contract's scope of services;</b>	APS contracted with TennCare, the designated Medicaid Agency for the State of Tennessee, to conduct quality assurance and compliance activities to complete the transition of enrollees from a county home and community-based waiver to a statewide waiver. APS' Registered Nurses conducted in-person enrollee interviews, reviewed the plan of care, and verified the delivery of services after transition. This intensive management approach ensured the medical necessity and quality of services

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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	and the safety of enrollees in their homes.
<b>(d) the contract term; and</b>	August 13, 2007 to February 28, 2008
<b>(e) the contract number.</b>	0822441000

**B.17. Provide customer references from five individuals (who are not current or former officials or staff of the State of Tennessee) for projects similar to the services sought under this RFP and which represent:**

- two (2) of the larger accounts currently serviced by the Proposer, and
- three (3) completed projects.

We encourage Proposers to provide references from administrators of other large, self-funded plans, particularly those serving public sector employees. Proposers shall not provide customer references from individuals who (a) are currently employed by the Proposer, its parent company, its subsidiaries, or any of its affiliates or (b) were employed by such entities at any point during the contract relationship in question.

All references must be provided in the form of standard reference questionnaires that have been fully completed by the individual providing the reference as required. The standard reference questionnaire, which must be used and completed as required, is detailed at RFP Attachment 6.4. References that are not completed as required will be considered non-responsive and will not be considered.

The Proposer will be solely responsible for obtaining the fully completed reference questionnaires, and for including them within the Proposer's sealed Technical Proposal. In order to obtain and submit the completed reference questionnaires, as required, follow the process detailed below.

- (a) "Customize" the standard reference questionnaire at RFP Attachment 6.4. by adding the subject Proposer's name, and make exact duplicates for completion by references.
- (b) Send the customized reference questionnaires to each individual chosen to provide a reference along with a new standard #10 envelope.
- (c) Instruct the person that will provide a reference for the Proposer to:
  - (i) complete the reference questionnaire (on the form provided or prepared, completed, and printed using an exact duplicate of the document);
  - (ii) sign and date the completed, reference questionnaire; (iii) seal the completed, signed, and dated, reference questionnaire within the envelope provided;
  - (iv) sign his or her name in ink across the sealed portion of the envelope; and
  - (v) return the sealed envelope containing the completed reference

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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questionnaire directly to the Proposer (the Proposer may wish to give each reference a deadline, such that the Proposer will be able to collect all required references in time to include them within the sealed Technical Proposal).

(d) Do NOT open the sealed references upon receipt.

(e) Enclose all sealed reference envelopes within a larger, labeled envelope for inclusion in the Technical Proposal as required.

## NOTES:

- The State will not accept late references or references submitted by any means other than that which is described above, and each reference questionnaire submitted must be completed as required.
- The State will not review more than the number of required references indicated above.
- While the State will base its reference check on the contents of the sealed reference envelopes included in the Technical Proposal package, the State reserves the right to confirm and clarify information detailed in the completed reference questionnaires, and may consider clarification responses in the evaluation of references.
- The State is under no obligation to clarify any reference information.

APS has included our sealed references in a separate envelope within our Original Technical Proposal within the tab marked "6.4 Reference Questionnaires."

**B.18. For each of calendar years 2006, 2007, 2008, and 2009 provide the average number of total members for the top five largest accounts for which you have provided health management and wellness services. Identify the type of account (e.g., commercial, Medicare, or Medicaid).**

Information on our top five (5) customers from 2006-2009 is presented below.

Year	Account Type	Average Membership (lives)
<b>2006</b>		
Blue Cross Blue Shield of Montana	Commercial	162,000
State of Louisiana	Commercial	135,000
State of Wyoming	Medicaid	56,000
State of Georgia (EC)	Medicaid	48,000
Micron	Commercial	35,000
<b>2007</b>		
State of Georgia (MMP)	Medicaid	214,000
Mississippi State and Teachers	Commercial	196,500

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Year	Account Type	Average Membership (lives)
Blue Cross Blue Shield of Montana	Commercial	175,000
State of Wyoming	Medicaid	54,000
State of Missouri (CCIP)	Medicaid	40,000
<b>2008</b>		
State of Georgia (MMP)	Medicaid	208,000
State of Missouri (ASO)	Medicaid	198,000
Mississippi State and Teachers	Commercial	195,600
State of Missouri (CCIP)	Medicaid	107,000
State of Nevada	Commercial	56,000
<b>2009</b>		
State of Georgia (MMP)	Medicaid	229,000
State of Missouri (ASO)	Medicaid	209,000
State of Vermont	Medicaid	150,000
State of Missouri (CCIP)	Medicaid	141,000
State of Nevada	Medicaid	61,000

**B.19. Describe your safeguards to protect the privacy and confidentiality of all members and to prevent unauthorized use or disclosure of Protected Health Information (PHI) that you create, receive, transmit, or maintain related to the medical benefits covered in this Contract. Please also describe any security breaches involving more than one hundred (100) members during the last two (2) years and explain the corrective actions that you are taking to mitigate risks for any future breaches.**

## APS' Philosophy and Commitment to Confidentiality & HIPAA

APS is committed to ensuring confidentiality and HIPAA compliance throughout all of our operations. Every individual deserves to have their personal health and medical information respected and kept confidential as mandated by federal and state law. In alignment with this, our philosophy is to create a HIPAA minded work culture where APS associates are trained and reminded to treat the personal health information (PHI) of the people we serve as if it were our own. Such information should only be used or disclosed on a minimally necessary basis in accordance with relevant law and regulation. Extreme care, sensitivity and respect should be exercised at all times when handling personal health information. Any employee of APS can create a potential liability for the company, jeopardize the privacy of the people we serve, and harm our reputation if we are not aware, informed and able to incorporate the Privacy and Security Rules contained in HIPAA into our responsibilities at APS. APS considers violations of any of the provisions of HIPAA to be extremely serious; so serious that individuals may not be welcome to continue their employment at APS if they commit a violation. APS is committed to

**\*\* Information shaded above is considered CONFIDENTIAL & PROPRIETARY. See Exhibit A for details. \*\***

# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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helping facilitate an environment where HIPAA is a priority.

## **Safeguards to Protect Member Protected Health Information (PHI)**

APS has been and will continue to comply with all HIPAA privacy, security and transactional code set requirements to ensure we protect the privacy and confidentiality of all members and prevent unauthorized use or disclosure of PHI that APS creates, receives, transmits, and maintains related to the medical benefits covered under the State's Program.

For example, APS continuously reviews processes, policies, and procedures to ensure ongoing compliance. To ensure our operations and practices are compliant with HIPAA on an ongoing basis, APS has a Chief Privacy Officer, Michael Williamson, who is committed to ensuring HIPAA compliance. We also have a Chief Security Officer (CSO) who is responsible for monitoring security issues and adhering to the HIPAA Security Rule across the organization.

Additionally, we have fully established HIPAA Policies and Procedures that apply to all APS personnel and systems. For example, formal workforce security procedures ensure all workforce members have appropriate training and must adhere to all policies and procedures before being permitted access to electronic health information. Employees are also required to participate in annual HIPAA training to make sure that they understand security and privacy rules and our commitment to their consistent application. In fact, APS achieved 100% associate compliance with its HIPAA training in 2009.

Furthermore, our legal and account teams ensure we have the appropriate business associate contracts and agreements in place. APS has implemented a number of contracts since the roll out of HIPAA and we have successfully managed these transactions and transitions for other state programs – APS will do the same for the State if awarded the contract.

## **HIPAA Security Breaches**

APS confirms that we have not had any security breaches involving more than one hundred (100) members during the last two (2) years.

## **APS CareConnection® - A HIPAA Compliant System**

APS will employ our HIPAA-compliant management information system, APS CareConnection®, for the State's Program. APS CareConnection® operates in a HIPAA compliant environment and complies with all three of the key HIPAA areas as discussed below.

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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- **Privacy** - APS systems are designed and maintained to protect the privacy of PHI. This is driven through a combination of processes and system configuration. Password access at two levels prevents unauthorized access to our systems containing PHI. Even with a password, staff is limited by a "need to know" policy – having access only to the "virtual file cabinet" of consumer information for whom they serve. For example, a clinician serving the State's members will not have access to patient information for members covered under another client's contract. In addition, APS is capable of tracking access to records, so we know who last viewed or changed a record. Physical systems also promote security. Mandatory use of password protected screen savers, set to 10 minutes or less of inactivity, are required of all personnel with access to PHI. All backup tapes are maintained in a secure environment, both onsite and off. Server rooms are kept locked and are accessible only to the appropriate engineering and operations staff.
- **Code and Transaction Sets** - APS CareConnection® has always been code-set compliant with HIPAA standards. We use standard ICD-9 codes, and we work closely with customers to resolve issues regarding the use of long-standing local coding systems. APS offers a strong tool set and development team ready to successfully address code and transaction set issues. Using BizTalk and custom programming, APS is confident we can meet the State's needs while complying with the federal standards and guidelines.
- **Security** - The APS CareConnection® system and platforms it runs on are compliant with security requirements. As discussed above, we use strong passwords, and have a fully protected network, including firewalls at ALL external network access points and fully encrypted VPN's for all remote connections. APS supports established protocols that ensure the reliability of all information systems components. APS servers are backed up to tape every night. The saved data is managed in weekly cycles, including archiving the last full backup from the end of each month. APS maintains both on-site and off-site facilities for retention and storage of backup files and software. Tapes are stored offsite with a bonded, licensed national company with secure storage. APS inspects the site annually. Key servers are built with redundant hardware components to provide maximum availability. RAID-5 disk storage is used for production servers that allows for "hot swapping" of failed hard disks and spares on the shelf. This strategy allows the business to continue to operate in the event of a disk failure. The APS SQL server based system includes the appropriate checkpoint and restart capabilities necessary to ensure reliability and recovery, including disaster recovery. Transactions can be stored automatically to tape and restored to the identical server for disaster recovery purposes. The SQL server has the built-in capability to restart the server where it was interrupted according to committed and/or uncommitted transactions. This process is known as "roll-back" or "roll-forward."

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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**B.20. Provide a statement of whether, within the past five (5) years, either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any) has had a contract to provide health management and wellness services:**

- (a) terminated prior to the contract end date; or**
- (b) ended without the procuring party exercising a contract option to extend the contract;**

**If so, include an explanation of all relevant details. Specify whether or not the termination or decision not to exercise a contract extension option resulted from performance issues, and if so, detail any corrective action taken by the Proposer to address the issues.**

In January of 2010, APS received a notice from the Georgia Department of Community Health ("DCH") terminating APS' agreement to provide services under the Georgia Medicaid Management Program effective February 28, 2010. The end date for the contract was June 30, 2010. This action was taken on the basis of a provision that allowed DCH to terminate the contract on a "without cause" basis on thirty days notice at any time. No performance issues were cited by DCH.

With the exception of the above, APS confirms that within the past five (5) years, neither APS nor our parent organization, affiliates and subsidiaries has had a contract to provide health management and wellness services that ended without the procuring party exercising a contract option to extend the contract.

**B.21. Describe fully each instance (if any), within the last five (5) years, in which a federal or state regulatory entity has:**

- (a) imposed, against either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any), a debarment or suspension, regulatory action, or sanction (including both monetary and non-monetary sanctions) relating to medical claims administration contract(s); or**

- (b) issued, to either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any), a letter of deficiency or of corrective actions requested or required relating to medical claims administration contract(s).**

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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Neither a federal nor state regulatory entity has imposed a debarment or suspension, regulatory action, or sanction (including both monetary and non-monetary sanctions) relating to medical claims administration contract(s) against APS or our parent organization, affiliates and subsidiaries. APS also confirms that neither a federal nor state regulatory entity has issued a letter of deficiency or of corrective actions requested or required relating to medical claims administration contract(s) to APS or our parent organization, affiliates and subsidiaries.

**B.22. Provide a statement of whether, currently or within the past five (5) years, either the Proposer or the Proposer's parent organization, affiliates, and subsidiaries (if any) has been the subject of a criminal or civil investigation by a state or federal agency other than investigations described in response to items B.8. and B.10. If so, provide a detailed explanation of all relevant details as well as the outcome (if the matter was concluded).**

In February, 2010, APS received a subpoena from the United States Department of Health and Human Services Office of the Inspector General, requesting information relating to one of the programs APS administers. APS is fully cooperating with this request and supplemental discovery, and is confident that its administration of the program was proper. Other than this request for information, APS is not the subject of an inquiry.

**B.23. Provide a description of your organization's relevant accreditations, including but not limited to your current National Committee for Quality Assurance (NCQA) and URAC, formerly the Utilization Review Accreditation Commission accreditation status, as well as any awards or superior performance recognitions. Please provide data on your Disease Management (DM) performance measures in the area of Comprehensive Diabetes Care (including all measures, if available) for your three largest programs. Please provide the measures for every year in which you operated that program and, if applicable, any baseline measures. As part of your response please include the contact at the organization who received the data and explain any confounding factors that may explain, in whole or in part, the changes in the performance measures.**

### **APS' Accreditations & Awards**

The quality of APS' programs is reflected in our accreditations and program awards. Our disease, case, and utilization management programs are already accredited by URAC, the primary standards and quality review body for the healthcare industry. APS is also recognized by CMS as a Quality Improvement Organization (QIO) entity, certified to conduct quality improvement activities in all states. This certification entitles states to receive an enhanced federal match for eligible services. APS' credentialing and re-credentialing procedures meet or

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## **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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exceed current NCQA standards.

APS has also received industry recognition for promotion of Best Practices. We have been the recipient of multiple Disease Management Association of America (DMAA) awards. APS' awards include:

- 2009 DMAA: The Care Continuum Alliance Award for Outstanding Government Program (Missouri HealthNet Chronic Care Improvement Program)
- 2008 Health Industries Research Companies' Most Effective State Medicaid Disease Management Programs (States of Georgia and Wyoming)
- 2007 DMAA: The Care Continuum Alliance Award for Best Government Program for Georgia Enhanced Care Program
- Top Government Disease Management Program in 2007 and 2006 by Health Industries Research Companies (HIRC). Named one of the Top 10 Disease Management Companies in 2007 and 2006.
- 2006 DMAA: The Care Continuum Alliance Award for Outstanding Provider Engagement for Georgia Enhanced Care Program
- 2005 DMAA: The Care Continuum Alliance Award for Best Government Program for Wyoming Health Management Program

Additionally, on May 12, 2009, our client, the State of Ohio, had the distinction of appearing before President Obama to give testimony about its innovative workplace practices developed by APS. Ohio was one of only seven employers who were invited to meet with the President to discuss best practices. The intent of this meeting was to examine successful employer wellness and prevention practices that lower health care costs and improve employees' health and to explore the feasibility of developing such a plan for federal employees and their workplaces. This recognition is particularly relevant to the State as our Ohio program provides similar services requested by the State (wellness, disease management, nurse line, health screenings), and demonstrates our success in administering the type of program the State envisions.

Furthermore, as stated in Item A.10 of our proposal, APS confirms that we will obtain National Committee for Quality Assurance (NCQA) and URAC accreditation for the Tennessee Program as required in Contract Sections A.13.h. and A.13.i. and referenced in Contract Section A.22 for the Tennessee Service Center, which will serve the State's program. In fact, we have already spoken with NCQA and conducted an organizational gap analysis regarding our accreditation readiness. Additionally, our disease, case, and utilization management programs are already accredited by URAC. We believe our efforts thus far will enable us to successfully achieve the accreditation requirements of the State's RFP.

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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## Exemplary Performance in Diabetes Management

APS has provided results of our diabetes program for our three largest customers offering diabetes management in the following paragraphs:

### The State of Wyoming

Since July 2004, APS has provided a total population management program, *Healthy Together!*, with a comprehensive array of services to Wyoming EqualityCare (Medicaid) participants to facilitate healthy behaviors and self-management of illness. The program provides health and wellness services for all program enrollees, and coordinates care management services for those with severe illness or disease, to decrease preventable, costly complications of chronic diseases. Diabetes results for the past three years are provided in the table below:

Diabetes Measure /Description	2004	2005	2006	2007	2008
1 HbA1C test (HEDIS like) / Percent of members with diabetes who had at least one A1C test in the measurement year	23%	23%	31%	37%	60%

In 2004, our baseline measure for one (1) annual Hemoglobin A1c (HgbA1C) test was 23%. Prior to 2008, APS' performance metric was based purely on claims data. However, in 2008, we were able to significantly increase compliance with this measure as we were allowed to include self-reported data. Contact information for this program and supporting data is provided below:

Contact & Title	Michelle Harker, Medical Care Coordinator
Phone	307-777-5854

### The State of Missouri

In 2006, APS began providing enhanced primary care case management for MO HealthNet (Medicaid) members. Incorporating the principles of disease management, care coordination and case management, the program serves vulnerable members identified with asthma, cardiovascular disease, chronic obstructive pulmonary disease (COPD), diabetes, gastroesophageal reflux disease (GERD), and sickle cell disease. The focus of the program is to improve the quality of care for participants with chronic illness, decrease complications associated with chronic illness and reduce costs associated with delivering care to this population. The State has expressed its satisfaction with the program's clinical results thus far:

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Diabetes Measure /Description	2006	2007-2008	2008-2009
1 HbA1C test (HEDIS like) / Percent of members with diabetes who had at least one A1C test in the measurement year	*	43%	44%

\*Data not available due to contract implementation and ramp-up period.

While the table reveals only a 1% increase from year 2007-2008 to 2008, this is due to the increased enrollment of over 100,000 members in year 2008-2009. In this year, we focused our efforts on engaging the newly enrolled members who did not have the appropriate tests during this measurement period.

Contact information for this program and supporting data is provided below:

Contact & Title	Jayne Zemmer, Program Manager
Phone	573-751-1612

## The State of Ohio

In 2007, APS was chosen to partner with the State of Ohio to deliver a Population Health Management (PHM) program, which included Disease Management, Wellness (i.e., Health Risk Assessment/Questionnaire, online disease prevention/wellness programs, health (biometric) screenings), and Nurseline services with 100% follow-up for members who engage in the PHM program's activities. APS' program model for the State of Ohio includes a Columbus, Ohio Service Center as well as field-based Outreach Coordinators and Health Coaches who provide program promotion and education to further engage members and help them effectively change their at-risk behaviors. Results regarding the State of Ohio's diabetes program since its inception are provided below:

Diabetes Measure /Description	2006 – 2007 (Baseline)	2007- 2008 (Year 1)	2008-2009 (Year 2)	2009-2010 (Year 3)
1 A1C test (HEDIS like) / Percent of members with diabetes who had at least one A1C test in the measurement year	43.80%	39.0%	53.0%	55%

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Over the course of our partnership with the State of Ohio, we have worked to continuously improve upon on the program's clinical measures. The decrease in Year 1 from our baseline data was due to a number of factors including our focus on managing other multiple priorities at the State's request as well as launching and transitioning the program to APS (e.g., focused on program marketing and engagement). However, we were able to increase compliance with the diabetes measure in Years 2 and 3 by working with the State of Ohio to target the most critical clinical metrics as a primary focus for that year. This included ongoing, proactive assessment of clinical measure performance prior to year end as well as implementing our proprietary analytic process that enabled us to prioritize member outreach based upon their risk factors, ensuring the highest risk/non-compliant members were contacted first. We have added an additional 20,000 members in Year 3 and focused our efforts on engagement of these newly enrolled members who did not previously take the A1C test. The measurement period for Year 3 is ongoing.

Contact information for this program and supporting data is provided below:

Contact & Title	Mary Ellis, Benefit Manager
Phone	614-644-1802

### B.24. Describe your business continuity and disaster recovery plans for all information systems including your system back-up processes.

APS deploys a best practice-based Disaster Recovery plan combined with a Business Continuity (DR/BC) Plan. This DR/BC Plan covers all levels of availability – from real-time through extended disaster. There are several components to the DR/BC Plan:

- **Availability Management:** APS follows an ITIL-based process for aligning service availability with business requirements. The resulting availability plan ensures the appropriate and pragmatic availability of critical services across a spectrum of options. As an example, services requiring 24x7 availability are implemented with high availability solutions (e.g. clustering). Each system component is addressed a RPO (recovery point objective) and RTO (recovery time objective) that drives the solution put in place to ensure appropriate backup content and windows as well as restoration timeline.
- **Existing DR/BCP Operations and Upkeep:** With the implementation of a new service, including a new customer program, the existing DR/BC Plan is updated to ensure ongoing alignment with business needs. This plan is reviewed annually or with any major business change. Additionally, a site-level disaster recovery test is performed annually.

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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- Situation Communications: the DR/BC Plan includes a communications plan for all stakeholders of system services, including the ultimate end-user / customer. For customers, this communication can consist of a variety of communication methods and media (e.g. email, phone calls, fax, etc.).
- Restoration of Services: The DR/BC Plan contains a detailed plan with individual activities for sequence and nature of restoration of services in the event of a disaster. Note that services deemed as requiring a high level of availability will NOT have to go through this plan (i.e. will not incur an outage). For high availability services (e.g. mission critical applications, telecommunications, networking and database), APS maintains a high availability redundant architecture. This architecture consists of clustered, redundant system components in two (2) data center facilities. The primary data center is in Brookfield, Wisconsin. The backup data center is in White Plains, New York in our corporate offices. In this model, data is mirrored real-time with SAN-level bit mirroring to keep both systems in constant synchronization. In the event of an outage in Brookfield, the White Plains servers will take over without noticeable impact on the end user. Our network and phone systems are similarly configured, with multiple, redundant connections across numerous sites and from numerous vendors.
- Resumption: The DR/BC Plan also contains the activities to restoring core services at the affected location to return to normal operations.

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## SECTION C: TECHNICAL QUALIFICATIONS, EXPERIENCE & APPROACH

**C.1. Provide a project implementation plan describing the steps that the Proposer will take upon approval of a contract resulting from this RFP to be prepared to assume all responsibilities described in the Pro Forma Contract (RFP Attachment 6.6) as of the go-live date specified in Pro Forma Contract Section A.22. Include the following:**

- (a) an itemization of activities that the proposer will undertake during the period between the awarding of this procurement and the start date of the program. These activities shall have established deadlines and timeframes and as needed conform to the timelines established under this RFP;**

APS has provided a proposed implementation plan as **Exhibit K** itemizing the activities to be undertaken during the period between the award of this procurement contract and the start date of the program. The itemized activities conform to the schedule of deliverables and milestones detailed in the RFP Section A.22.

- (b) tasks associated with the proposer's establishment of a "project office" or similar organization by which the proposer will manage the implementation of the health management and wellness program;**

APS' proposed implementation plan details the tasks associated with opening our "project office"/ dedicated service center in Tennessee to serve the State's membership and provide person-centered, provider-collaborative and technology enabled health management and wellness program services. Tasks and milestones include the following:

The following tasks are from the implementation plan regarding establishing a project office.

Facilities	Responsible Staff	Target Start	Target Completion
Notification to Facilities Development of Award	Wendy Lanski	07/13/10	07/16/10
Assignment of Facilities Manager	Dir. APS Facilities	07/19/10	07/21/10
Assessment of Facilities Need and Development of Facilities Project Plan	Dir. APS Facilities	07/19/10	07/21/10
Selection of Location Confirmed	APS Facilities Manager	07/21/10	08/10/10
Lease Executed	APS Facilities Manager	08/10/10	08/20/10
Assessment of Need to Build	APS Facilities Manager	08/23/10	08/25/10
Permits for Building Obtained	APS Facilities Manager	08/23/10	08/27/10
Networking Equipment is Ordered	Julie Smith	09/01/10	09/01/10
Furniture & Equipment Ordered	APS Facilities Manager	09/01/10	09/01/10

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Facilities	Responsible Staff	Target Start	Target Completion
Lease Start Date	Wendy Lanski	09/01/10	09/01/10
Network Equipment is Installed and Connectivity is Completed	Julie Smith	09/01/10	09/20/10
Construction Complete	APS Facilities Manager	09/01/10	09/20/10
Furniture Installed	APS Facilities Manager	09/20/10	09/24/10
Post Office Box Ordered	APS Facilities Manager	09/01/10	09/15/10
Provide Staff List and Location Assignment to Facilities Lead	APS Facilities Manager	ongoing	ongoing
Move In	APS Facilities Manager/Wendy Lanski	10/01/10	10/01/10

We will open a Tennessee Service Center for approximately 89 staff members who will serve the State's membership based on full program implementation (and finalized dependent upon elements purchased). APS will have a Nashville, Tennessee-based Service Center and remote staff deployed throughout the State.

One of the cornerstones of APS' success in providing top tier services for our clients is our local service center model and staffing key positions with experienced personnel. The local, service center model is preferred for serving the government contracts that APS supports because it provides the kind of dedicated attention to members and providers that is needed in order to facilitate system change and cost savings. In fact, we have established service centers staffed with local employees in California, Georgia, Hawaii, Missouri, Ohio, Oregon, Pennsylvania, Wyoming, and Vermont. The local service center approach succeeds, as it allows APS' key management and staff to have daily contact with state officials and providers and frequent face to face meetings as appropriate. This visible contact allows for the exchange of ideas, collaboration, trust and problem solving for member and provider-specific concerns.

The local service center approach is also successful because it is dedicated to one program and one customer – the State's health management and wellness services program. This approach results in excellent staff morale, a shared mission of positive outcomes, and quality care for members. The end result is a program that demonstrates clinical excellence and sound fiscal results.

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**(c) a roster of the implementation team members detailing each member's primary work location, roles, and responsibilities;**

APS utilizes dedicated implementation staff team members who know one another, work together on all implementations and have established relationships. Our team communicates their needs and expectations to assure results. APS programs are implemented locally and supported by national/functional expertise. We feel that a dedicated team, like APS', whose primary function and role is implementation results in flawless execution and results.

We will launch the health management and wellness services program with experienced APS key staff members as we have detailed below, who have a proven track record of successfully implementing and operating health management programs.

The following table indicates the key APS executives and staff who will be actively involved in the implementation of the State's program and where they will be physically located during program implementation.

Function	Name	Title	Location	Role/Responsibilities
<b>Executive Lead</b>	David Glazer	Senior Vice President for Operations in the Eastern Region	NY	Provide executive level oversight of the State's Program during implementation and throughout contract.
<b>Implementation Lead</b>	Wendy Lanski	Director of Implementation	Based in NY but in TN during implementation	Responsible for overseeing the successful implementation of the State's program
<b>Clinical Product Development</b>	Megan Cormier, RN	Vice President, Clinical Product Development	WY	Responsible for providing consultation regarding the clinical design of the State's program during the implementation phase.
<b>Medical Director</b>	Chelmer Barrow, D.O	Medical Director	MO	Act as the Medical Director to the State's program during the implementation phase and be responsible for providing clinical guidance and feedback regarding the program's

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Function	Name	Title	Location	Role/Responsibilities
				development.
<b>Analytics</b>	Erik Goetz, MBA	Vice President of Analytic Development	WI	Responsible for overseeing the analytics component of the State's program during the implementation phase.
<b>Analytics</b>	Michelle Beadle	Vice President, Analytic Services	NY	Responsible for coordinating the analytics analyses for the State's program during the implementation phase.
<b>Information Technology</b>	Greg Flanagan	Chief Information Officer	TN	Responsible for ensuring all components of our management information system, APS CareConnection, as well as reports meet the State's requirements
<b>Information Technology</b>	Julie Smith	Director of Information Technology (IT) Field Support	NY	Responsible for working with Mr. Segev to ensure all components of our APS CareConnection meet the program's requirements
<b>Executive Oversight - Onsite</b>	To be hired	Executive Director	TN	Holds ultimate responsibility for ensuring the success of the State's program.
<b>Account Management</b>	To be hired	Account Manger	TN	Responsible for overseeing the day-to-day functions of the program.
<b>Account Management</b>	To be hired	Project Coordinator	TN	Will provide back-up support to the Account Manager.
<b>Financial Contact</b>	Gordon Rothrock	Senior Vice President of Finance	NY	Will be responsible for ensuring all financial components and processes are in place for the State's program
<b>Implementation Consultant</b>	Mary Nell Bryan	Consultant	TN	Responsible for advising APS on appropriate

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Function	Name	Title	Location	Role/Responsibilities
				staffing and project implementation
<b>Subcontractors</b>	Implementation Staff from eDoc4U, Vanderbilt Institute for Obesity and Metabolism, Summit Health and Carenet		TN TN MI TX	Support APS' implementation initiatives

During the implementation phase of the health management and wellness services program, we will recruit, screen, hire, and train local program staff. This approach means that we bring the corporate skills and experience to bear to implement and launch this important program as we prepare for the operational start date of the Nashville-based operations staffed with staff that will bring local knowledge and experience to the health management and wellness services program. This reduces their learning curve and enables us to begin the project with the relationships, contacts, and practical know-how needed to succeed at the local level.

APS will also have our local consultant, Mary Nell Bryan, join the implementation team to assist in identifying appropriate staff for the State's program. Mary Nell is a local Tennessean and has been working with APS to identify local partners that will provide value to the State's plan by working with our organization. She has a passion for supporting health and well-being programs and is actively involved in various capacities with local well-being related organizations including the Tennessee Obesity Task Force, Campaign for a Healthy and Responsible Tennessee and the Tennessee Healthy Weight Network. Mary Nell will continue to provide ongoing support to the program in an active advisory capacity.

Biographies of these key staff are provided in **Question B.12** above.

**(d) a comprehensive description of activities related to information systems, including data interfacing/integration with critical systems and intake and assimilation of transition data;**

APS' health management system, APS CareConnection, is a program that exists and can be easily and quickly customized for the State's Health Management and Wellness Program. During implementation we will configure this system to include specific Plan eligibility

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specifications, condition-specific plan of care algorithms, and links to the State's sites. This also includes focusing on data transmission activities such as file testing, establishing secure FTP sites for data transmission, reviewing test claims files for informatics analyses. For example, we assure the State that at least seventy-five (75) days prior to the go-live date, APS will complete testing of the transmission, receipt, and loading of the eligibility/enrollment file from the State. No later than one (1) month prior to the go-live date, APS will also certify in writing to the State that we understand and can fully accept and utilize the eligibility/enrollment files as provided by the State.

Additionally, Julie Smith, APS' Director of Information Technology Field Support, will act as the State's designated IT Director during the implementation process. Specifically, she will spend 50% of her time during the implementation period working with the State's representatives and key internal APS staff to ensure all the IT components of the program are functioning properly and are compliant with the State's requirements. Julie will also be available 60 days after the program's go-live date to ensure all IT operations continue to run smoothly.

Greg Flanagan, Chief Technology Officer, is a resident of Nashville and will play an active role in the support of our technology needs for the State of Tennessee. Specifically, Greg will be involved during the implementation as a partner with Julie Smith and will also maintain an ongoing presence in support of the Tennessee program.

**(e) identification of proposer expectations regarding participation by the State and/or its agents in the activities in the State and dependencies between these activities and implementation activities for which the State and/or its agents will be responsible.**

We have successfully implemented hundreds of accounts and millions of lives with minimal resource allocation by our clients. Our strategy to successfully implement the State's program is for us to take the lead on all implementation tasks. Therefore, we will not place an undue burden on the State during the process.

In order to facilitate our efforts, we will need your help in identifying and communicating your goals to your key staff and benefit partners who will have a role in ensuring your objectives are met. We would strongly recommend that immediately following the contract award, you schedule a meeting at which you take the opportunity to include your key internal representatives and external partners, including your new program partner - APS. This meeting is a prime opportunity to assure that everyone understands your program objectives and the importance of working together to ensure success.

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Basic information that we will need from the State to facilitate coordination, cooperation and communication will include:

- Designation of a key contact that will be accessible and work with us to obtain the necessary information regarding your current benefit partners and the applicable benefit plans.
- Designation of a key information systems/technology representative who can work with us to provide the necessary claims data, including format and exchange methodology and clean eligibility files, in order to perform the analyses for identification of individuals for enrollment in the program.
- Contact information for all of the State's partners so that we may appropriately coordinate care.
- List of individuals who are already receiving health management and wellness services and development of a transition plan to ensure their effective and seamless transition to APS' health management and wellness services Program.

During the implementation phase, we will work collaboratively with the State's representatives to ensure your program meets your expectations. This includes obtaining your valuable feedback and insight on how we can best position our approach to ensure a positive interface between your program, your members and their providers. We will also coordinate with our internal operational experts to ensure your program is implemented in the smoothest fashion possible. Specifically, we will ensure:

- All program components are fully understood and integrated into the delivery of services;
- Any data transfer needs, reporting issues and system capabilities (e.g., monthly eligibility data, etc.) are effectively identified and addressed; and
- Any issues or concerns are quickly identified, addressed and resolved throughout implementation process.

We have a proven track record of successful client implementations and are confident that we will be fully operational and have all processes and procedures in place by the State's proposed start date.

**(f) the dates on which the implementation team would share first drafts of the health questionnaire, risk stratification approach (including method for identifying and enrolling members into health management and wellness programs, as indicated) and related member materials and web resources that the implementation team would propose to use for this project;**

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APS' implementation team will present the first drafts of the requested information within the timeframes referenced below, but before the State's deliverable dates as detailed in section A.22 of the pro forma contract:

Item	Draft Presented	Final Deliverable Due Date
Health Questionnaire	July 5-16, 2010	September 1, 2010
Eligibility Criteria and Risk Stratification Procedures	July 19-30, 2010	September 1, 2010
Brief Summary of Health Questionnaire and Continuum of Services for Member Handbook	July 5-16, 2010	September 1, 2010
Preventive Health Messaging Annual Plan	August 2-13, 2010	October 1, 2010
"Take this to Your Doctor" Checklist(s)	July 12-23, 2010	August 15, 2010
Website/Portal	September 6-17	October 15, 2010
Updated Information Based on New Plan Year	September 6-17	October 15, 2010
State Review of Website and all Materials on Website	September 6-17	October 15, 2010

### (g) the project timeline and a schedule of meetings between the implementation team and the State;

The proposed implementation plan (**Exhibit K**) includes routine implementation meetings with the State at least twice a week to ensure all issues are addressed on a timely basis and to facilitate communication between all parties. We will schedule the actual days and dates of those meetings at the State's convenience. We will also conduct routine daily meetings of the APS dedicated implementation team to monitor progress and allocate resources. We also recommend weekly implementation meetings with the State's other external benefit vendors and internal health initiatives to establish "just in time" cross referral protocols and facilitate data exchanges. For the two weeks prior to and the first month following the go-live date, APS will meet daily with the State.

### (h) anticipated frequency of updates to the implementation plan.

APS will monitor the success of the implementation through daily updates to the project implementation plan. The general flow of our project implementation plans has proven to be

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extremely successful with other large customer implementations. However, we will regularly update and monitor the nuances of the State's implementation plan as needed.

During implementation, we will submit status reports to the State summarizing key milestones achieved during the week, status of tasks in process, and any obstacles that are encountered, submitted jointly with relevant contingency plans for overcoming the obstacles. Internally, we will meet with all staff related to the project on a daily basis to review their progress and identify any areas where additional resources may be needed to accomplish goals.

After the Implementation (after *go-live*), the Implementation Project Manager, Ms. Wendy Lanski, will not drop off immediately, she will remain involved (typically not client facing) to support internal APS processes. In collaboration with the Executive Director and Account Executive, the Project Manager:

- Tests the phone lines to verify that routing is accurate and recorded correctly
- Reviews the incoming call volumes and daily interactions with operations
- Reviews the first set of monthly reports internally for accuracy

We will continuously maintain a schedule of deliverables, and review this regularly at these meetings to assure all program requirements are met. Additional expertise for implementation, consultation, and backup will be made available as necessary via our team of management staff and corporate resources.

### **C.2. For the proposed Account Team for this Contract describe:**

**(a) how the implementation team will be phased out and replaced by the ongoing Account Team and provide projected dates;**

APS' approach to implementation involves our blended Implementation/Development/Account Team approach whereby the Implementation Lead spearheads the entire program launch, but is supported by the program's Account Team. While the Implementation Lead is ultimately responsible for a successful implementation, the program's Account Team is involved in the program's implementation. Additionally, other key executives and senior operational staff who participate in the implementation process remain available after the program's launch as needed for ongoing guidance and support. By involving these staff members in such a critical period, the Account Team and supporting staff are afforded an intimate understanding the program's scope of work and any challenges that may arise during the launch and how those issues were addressed. Along with this historical knowledge, these individuals are able to begin building positive working relationships with the customer's key staff to ensure all operations

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continue to run smoothly after the program's go-live date. Once the contract goes live, the implementation team is phased out and transitioned wholly to the Account Team.

APS will take the same approach with the State's Health Management & Wellness Program. Your Implementation Manager, Ms. Wendy Lanski, will be responsible for working closely with our key executives, operational staff, as well as your Executive Director, Account Manager, and Project Coordinator once they are hired. Wendy will involve these individuals in various key tasks throughout the implementation process so that they understand the State's expectations, culture and program's operations including rationale for decision making, protocols, data exchange needs and program performance standards for example.

Additionally, prior to the program's go-live date, Wendy and the State's Account Team will meet internally more frequently to ensure the transition is smooth. Specifically, since the State's Health Management & Wellness Program goes live on January 13, 2011, Wendy will anticipate transitioning leadership of the program between January 13<sup>th</sup> – January 28<sup>th</sup> (1-2 weeks after the go-live date). Our local consultant, Mary Nell Bryan, will also transition from the Implementation team to be part of Account Team in an active advisory capacity. It's important to note however that Wendy and other implementation team members will be available to the State's Account Team as needed after the program's go-live date. Our Implementation/Account Team approach to transition has been successful for our other contracts, and we believe it will result in a seamless transition for the State.

**(b) how the Proposer will ensure a smooth transition between the teams with minimal disruption to the State and members and whether the Proposer would commit to extending on a temporary basis the work of key implementation team members after the initial implementation period upon the State's request;**

As stated above, Wendy, who will act as the State's Implementation Lead, will work collaboratively and closely with both our existing staff and the State's Account Team once they are hired. Mary Nell Bryan will also support the transition and remain part of the Account Team from her role on the Implementation Team. Early in the implementation process, we will aggressively screen and recruit members of your Account Team including the Executive Director, Account Manager and Project Coordinator so that they begin engaging in the implementation process as soon as possible. In the interim, our key executives and senior operational staff will work with Wendy and Mary Nell to ensure project deliverables are met and issues are resolved on time. Once your Account Team is hired, they will be trained and brought up to speed with regard to the implementation's status by Wendy and Mary Nell. As the contract's go-live date approaches, Wendy and Mary Nell will work intimately with your Account Team to go over each deliverable, the status of the deliverable, the staff person responsible for completing the task, any issues/challenges surrounding the task and identified

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solution for addressing the issue/challenge. Wendy and your Account Team will meet on a daily basis during the final weeks of implementation to ensure each facet of your program is in place prior to the program's launch to ensure minimal if any disruption to the State and your members. Furthermore, we are more than happy to extend the assistance of key implementation team members after the initial implementation period at the State's request.

**(c) how the Account Team will work with the State, outside of regularly scheduled meetings, to identify opportunities and respond to issues that arise in the industry to ensure the State manages its medical benefits in a timely, cost effective, and judicious manner;**

APS understands that issues may arise at any time that may impact the State's program and/or your members. As a result, your Account Team – from your Executive Director, Account Manager and Project Coordinator (back-up) - will be readily available to the State to meet outside of the regularly scheduled meetings to identify opportunities and respond to issues that arise in the industry to ensure the State manages its medical benefits in a timely, cost effective, and judicious manner. For example, the State's Account Manager will be available for consultation with the State between 8:00 a.m. to 4:30 p.m. Central Time, Monday through Friday, and be available via cell phone and email after hours, including weekends.

At APS, our account teams, which are comprised of seasoned industry professionals, act as consultants to our customers regarding their program operations and the healthcare industry as a whole. In fact, many of our Executive Directors and Account Managers have over 10+years of experience in the healthcare industry and Masters degrees in their respective fields, all of which enables them to think critically about the program's needs, identify trends within the program and industry, as well as opportunities for program improvements on an ongoing basis. Your Account Team will also have access to corporate resources, including our Legal Department, to ascertain changes in the healthcare market and how those changes impact the State's Health Management & Wellness program. This includes acting as a subject-matter resource to the State by responding to specific inquiries and providing information to the State on emerging best practices and applicable existing and proposed Federal and State laws and regulations that affect health management and wellness programs. Additionally, since your Account Team will be housed locally within our Tennessee-based service center and dedicated to the State's contract, they will be able to easily meet with the State's representatives in person at your request.

**(d) how the Account Team will escalate, as necessary, and resolve issues of importance to the State; and**

High level issues identified by the State will be personally handled by our Executive Director and/or the program's dedicated Account Manager. These individuals will meet with the State

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on at least a monthly basis to discuss the program's performance including identifying issues of importance to the State for expeditious resolution. In accordance with the State's requirements, the Account Manager will respond to all inquiries in writing from the State within one (1) week after receipt of the inquiry. If more time is necessary to resolve the issue, the Account Manager will notify the State immediately as to when the response can be furnished to the State. For issues designated as urgent by the State, APS will escalate the issue, coordinate with the appropriate internal APS departments for resolution, and provide the State a response within four (4) hours during normal business hours or within twenty-four (24) hours during non-business hours.

Furthermore, our Member Services Supervisor, who will act as the State's Client Service Liaison, will be responsible for responding to member-related issues identified by the State. Again, urgent issues will be escalated for prompt resolution. This includes contacting the member to resolve the issue and notifying the State once the issue is resolved.

**(e) any evaluation tools that the Proposer offers for State use in providing formal written evaluation of the Account Team's performance, the projected frequency of such feedback and how the Proposer will use it to improve performance.**

APS offers the State our Account Management Scorecard (see **Exhibit L**) to capture satisfaction data regarding the performance of your dedicated Account Manager, and will use it as a quality improvement tool. We will customize the Account Management Score Card to your needs and ensure it's compliance with accrediting bodies (e.g., NCQA and URAC) as applicable. The State's designated representative(s) can use the scorecard as a vehicle to provide formal written evaluation of your Account Manager on an annual basis. The scorecard captures information on:

- How the Account Manager addresses questions and concerns in a time-sensitive manner.
- How the Account Manager schedules meetings/conference calls with the State's representative to discuss our program and trends.
- How the Account Manager keeps the State's representative apprised of new products and services.
- How the Account Manager helps the State's representative craft/develop solutions to our business initiatives.
- Whether reports are received in a timely manner.
- Whether promotional materials are both engaging and informative.
- The overall satisfaction with the services received from the Account Manager.
- Whether the services provided by APS met the needs of the State.

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APS will then provide results on the Account Management Scorecard back to the State on an annual basis. This will include an action plan that outlines specific performance issues and steps to resolve those issues.

### **C.3. Describe how, for this contract, you will coordinate and organize the employment site screening events, including:**

#### **(a) Registering members, informing them of the events and scheduling appointments; and**

#### **Registering & Scheduling Members**

APS is the lead vendor and will take ownership of this process. APS will engage Summit Health who provides enrollment for screenings and telephonic coaching appointments using the following three methods:

1. Direct employee sign-up using Summit Health's proprietary Internet-based appointment system. This capability will be integrated into the program's member portal. There is a single sign on service, then its ParTners proprietary internet based system supported by APS' partner Summit Health.
2. By telephone using a toll-free number.
3. Sign-up with Site Coordinator (Site coordinator takes appointments and enters data using Summit Health's Internet-based system).

The online appointment system vastly increases participant satisfaction. By matching the number of appointments to the throughput of the screening team, waiting lines at the screening event are nearly eliminated. An email reminder the day before the event reduces no-shows. Because most people sign up quickly upon receiving the email invitation, the site coordinator or HR manager knows a week or more in advance what the expected turnout will be, and if low, can increase the internal awareness campaign. The site coordinator also has the ability to make appointments for those site employees who do not have access to a computer.

The Appointment System includes the following features (see screen shots of this process in **Exhibit S**):

1. Employee Registration by date and time (auto purge of prior year's names)
2. Email Appointment Confirmation
3. Special Requirements (e.g. Wheelchair)
4. Standby Status (waitlist) if time is full
5. Integration with Outlook Calendar
6. Email reminder the day prior to the clinic

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7. Secure email through encryption
8. Single-Sign-On (SSO) Capability
9. Private Labeling of Screens and Emails
10. Username & Password to view results on-line

### **Promoting and Marketing the Event**

As part of our promotional efforts, we will promote the State's health screenings to increase awareness and support your members in fulfilling the Partnership Promise. Promotional activities include sending out preventive messages via mail, email, telephonic messaging to remind them of upcoming health screenings. Promotional materials will also include outdoor health screening banners and table top displays at the health screening site. Lastly, with each interaction between members and their Wellness/Health Coach, Case Manager, and Health Promotion Coordinator, our staff will encourage members to complete their health screening, including assisting them with locating an event and scheduling an appointment.

Summit Health's marketing support also includes a comprehensive package of communication collateral to facilitate the communication and promotion of Summit Health service offerings. The materials encompass a series of time-specific communications and reminders from pre-launch to post-service delivery. Summit Health's communication portfolio consists of a turnkey communication continuum with high-impact user-friendly, print-ready collateral in a wide variety of media formats including:

- Emails
- Posters
- Flyers
- Postcards
- Paycheck inserts
- Announcement letters/memos
- Badges (Provided to participants at the event)
- And more to accommodate your particular communication culture.

The messaging of the communications collateral is simple, attractive, clear, concise, positive and friendly for maximum awareness and engagement. This comprehensive package of communication collateral facilitates the communication and promotion of offerings for a successful delivery of the planned programs, activities, challenges, and events. The materials encompass a series of time-specific communications and reminders from pre-launch to service delivery that:

- Introduce the program
- Are designed to trigger employee engagement

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- Provide information on the program content and process
- Increase awareness on the associated risk factors and diseases/ illnesses
- Allow for customization with the client specific unique brand identity logo

The communications, designed by our communication and public relation team with our medical and clinical professionals, promote programs that educate employees about how to make lifestyle behavior changes and participate in activities to improve health. The messaging encourages your population to take greater personal control of their health, make improvements and increase their readiness to do so. Please note that some items currently have a higher Flesch-Kincaid reading level than required at this time, but APS assures the State that these materials will be modified to a 6<sup>th</sup> grade reading level or less for the State's program.

## **Customization**

Our marketing materials can be branded with an organization's logo and special program messaging.

Those members of the State of TN staff involved with managing the events will receive a sign-on and pass code for access to all the collateral for downloading and customizing.

Over the years we've developed a finely tuned execution system that integrates state-of-the-art information technology systems, training and quality standards.

The approach to the design and management of our health screening programs is to listen to our clients so we understand their needs and expectations; and then deliver a customized turnkey solution for a successful program. Summit Health's health screening implementation processes are part of our turnkey programming. The overall program design and management services include pre-planning, administration, execution and evaluation of an event. Our goal is to minimize the time and effort that the client needs to spend on the program by managing all aspects of the program through a single point of contact (Program Manager) who is assigned to each account. Our clients receive a customized program guide that explains in detail the screening event at each site and who is responsible for what.

## **1. Overall Program Design**

- a) Define program requirements (e.g. screenings, venipunctures, coaching, spouses, co-pays, pricing)
- b) Develop staffing requirements
- c) RN, LPN, technician, phlebotomist, clerk
- d) Confirm clinic locations, dates, and site coordinator
- e) Define marketing, communication, and education campaign
- f) Estimate participation by site

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# **A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans**

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- g) Develop program rollout plan

## **2. Program Administration**

Determine requirements by site

- a) Contact client site coordinators to confirm clinic info
- b) Review conformance with Federal & State Regulations and file permits
- c) Develop customized procedure manual and training video
- d) Calibrate medical equipment prior to arriving at screening site
- e)

## **3. Clinic Administration**

- a) Select & schedule staff based on clinic requirements
- b) Assign Team Leader
- c) Establish back-up staff and procedure
- d) Receive medical equipment, supplies, and forms
- e) Verify medical equipment is working and calibrated
- f) Hold training session and certify staff
- g) Confirm directions, parking, and room with site
- h) Final confirmation call with site
- i) Travel to client site

## **4. Communication/Education Campaign**

- a) Confer with site coordinator to customize campaign
- b) Provide site coordinator with downloads & marketing materials
- c) Site Coordinators Market Program
- d) Appointments (On-site, Telephony, and Internet)
- e) Answer questions on 800 line

## **5. Clinic Execution**

- a) Arrive and contact site coordinator
- b) Verify table and chairs are set up
- c) Set up screening stations and administrative table
- d) Calibrate medical equipment
- e) Conduct clinic
- f) Team Leader monitors quality of program throughout event
- g) Summit Health contacts site coordinator for day-of-event feedback
- h) Clean up the event site
- i) Email satisfaction survey to site coordinator

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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- j) Document opportunity areas for improvement

## **6. Program Review and Improvement**

- a) Receive feedback from
  - i. Site coordinator
  - ii. Summit Health Local Staffing Managers
  - iii. Summit Health Account Executive & Program Manager
- b) Identify areas for program improvements
- c) Discuss and share feedback in daily conference calls
- d) Incorporate action items into future events
- e) Update Procedure Manual (Customized)
- f) Communicate target action items to the Client

### **(b) Managing the planning and scheduling logistics.**

**Describe the qualifications of the individuals who will be administering the employment site health screens under this contract. What training will they receive? How will you ensure the provision of quality screening and counseling?**

### **Screeners/Coaches**

APS will provide the oversight of our valued partner Summit Health. APS hired Summit Health because of the guarantee of staff with excellent credentials. Summit Health's on-site screeners/coaches are trained professionals, experienced in corporate wellness programs and behavioral change. With degrees in Health Education, Exercise Physiology, Counseling, and Exercise Science, each has at least a 4-year degree and three years' of experience. Many also hold a Master's or other advanced degree.

Summit Health only staffs its health screening events with qualified and trained personnel. New hires go through a rigorous background check and comprehensive training of our onsite screening program. Each staff receives rigorous training on the client-specific program prior to the event, and will do the same for the State's Health Management & Wellness Program. All applicants are carefully screened and must meet the following requirements for employment:

- Signed application with complete job history
- Experience requirements are met as specifically defined by the client
- Documentation of legal right to work in the United States
- Primary source verification of a current active and unrestricted license, certificate or registration
- A minimum of two professional references verifying most current work experiences

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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- Current and valid certifications as required by the job description or the contracting client
- Completed appropriate Skills Checklist
- Face-to-face or telephone interview
- Comprehensive background check

Summit Health has eight full-time recruiters who complete the reference checks by placing calls out to both professional references supplied by each candidate. Our recruiting staff conducts criminal background checks using a criminal background check service.

Additionally, APS Health Educators and Health Coaches will occasionally attend the screening events. Our goal is to create a trusting environment as much as possible so that State members who should enroll in a lifestyle, disease or case management program will be more likely to do so and improve their health. This is based on our experience in Ohio, trust is more easily and quickly established when you are working face to face.

**To the extent that you will allow/encourage members to obtain screens at laboratories/patient services center under this Contract, describe how you will ensure that members get all necessary elements of the health screening (e.g., height/weight and blood pressure). Also, describe the data transmission from said entities and how you will ensure members receive counseling after the screens.**

We currently do not receive these elements from laboratories. However, if our services expand to this capacity during the contract, we will work with the lab partner(s) to develop a solution for collecting these measures and provide appropriate counseling following the screen.

**C.4. Describe how, under this Contract, you will provide immediate feedback to the member upon completion of the health screening at any onsite event. Specifically, describe how you will explain to the member the meaning of the results. Additionally, provide a sample one-page feedback summary and any other education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece).**

Our program provides health coaching as an integral part of its on-site screening programs to provide additional information and support. We have chosen Summit Health as our partner for the onsite Health Screenings. This coaching is a basic part of Summit Health's service and not an optional or add on service. Summit Health believes this coaching is the greatest valued-added activity it can provide and lead to the highest return on investment (ROI) for clients.

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Summit Health uses a “single-station” model for wellness screening events. Participants meet with a Summit Health professional for 15 minutes for screening and coaching, which take place at the same station. This model leads to high quality coaching sessions that do not require employees to move between stations, thus enhancing employee satisfaction. The health coaching offered throughout the screening provides an important “teachable moment” for employees to better understand their results and how they can improve their health through lifestyle changes.

Throughout the health screening sessions with fingerstick blood draws, Summit Health coaches review employees’ results and answer questions. As part of the coaching, employees receive reports with their results along with national guidelines. For venipuncture (blood draw at service centers) and home test kit screenings, results are mailed to employees’ homes within 10 business days, followed by coaching via telephone.

Summit Health has created a variety of scripts to ensure consistent and accurate coaching across different sites and screening teams. Each coaching session includes:

1. Review of results
2. Comparison to national guidelines
3. Suggested lifestyle changes
4. Answer to questions posed by employees

Summit Health’s coaching staff is primarily nurses and health educators. Each coach is trained prior to an event and uses our coaching brochure and counseling script as a guide. Summit Health coaches do not diagnose, prescribe or give medical advice.

Additionally members are provided with a health screening handout (see **Exhibit Y**) with educational information as well as an area to log their health screening results.

### Medical Referral Process

Summit Health’s staff has referral guidelines for use with employees whose biometric results exceed recommended levels which are consistent with State requirements. These employees are asked to sign a commitment to share their screening results with their primary care physician (PCP). To monitor compliance, APS Health Coaches will follow up with employees and/or fax results to their PCPs.

If during a screening, an employee is found to have blood pressure or glucose levels that are dangerously high, the screening team will determine to whom he or she should be referred immediately. These referrals may be made to:

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- a) An on-site occupational health physician, if available
- b) A Summit Health medical director via telephone conference call
- c) A primary care physician
- d) The nearest emergency room

APS will provide oversight as well as an active role in this process. Additionally, APS Health Educators and Health Coaches will occasionally attend these screening events as well. The intent is to build trust with the member and Health Coach for ongoing engagement. APS Health Coaches will follow up with 100% of participants at a screening event.

**C.5. Describe how, for this Contract, you will ensure that all data from the health screens are accurately transferred and stored (e.g., specifically describe how data will be transferred from the collection site and secured/stored in your office/facility). Please describe this process for employment site screening events and at-home screening and laboratories/patient services centers (if applicable).**

Summit Health customizes Scantron® forms (bubble sheets) for each client. This sheet collects personal and biometric data on each individual. These sheets are scanned into our secure server which resides in a SAS 70 certified facility. Summit Health works with each client to develop a method to transfer this data in a secure manner to their systems. Summit Health will send this information to APS via a secure File Transfer Protocol (FTP).

An informed consent form will be customized with the State that will include all the data that needs to be collected. The informed consent forms will be sent back to Summit Health's corporate headquarters. At the corporate headquarters the forms will be scanned into a relational database using our Scantron system that will read information using Optical Character Recognition (OCR) and Optical Mark Reader (OMR). Information from the informed consent form (employee name, address, employee number) and biometric information will be loaded into the Summit Health secure relational database.

Summit health will also customize its informed consent form to meet the State's needs. In this case, the employee will need to sign-off on (give authority) for Summit Health to transmit their results to a third party.

The most effective way to guarantee accurate member number is to match the patient data obtained at the clinic to an eligibility file produced by employer. Summit Health will receive eligibility files for those individuals that are eligible for the health screenings from APS. This information will be sent via :

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- Excel (.xls or .xlsx)
- Comma Separated Values (.csv)
- Text (.txt)
- Zip (.zip)
- PDF

**C.6. Describe how, for this Contract, you will receive health screening information from physicians and other providers who provide health screenings in their offices. In what specific ways can the providers submit the information to you? How will you address situations in which the provider supplied incomplete information – or data in a format different than that you requested? What (if any) confirmation of receipt do you provide to the member? Also, what follow-up counseling or education would they receive – and would they receive this by phone, mail or other medium? Please provide the same information for laboratories/patient services centers (if applicable).**

APS will receive screening information from providers via hardcopy mail or fax, assuming the provider uses the State developed screening form. It will then be populated into CareConnection and the member's health questionnaire. We will also take this information directly through the CareConnection Provider Portal.

In situations where we receive incomplete information, we will contact the provider's office for complete information. APS will acknowledge receipt of information to the member using the member's preferred communication method: mail (must include address), telephone (must include number) or email (must include email address).

An APS Health Coach will follow up with 100% of State members who complete a health screening whether onsite, at a provider's office or lab, or via home kit. The counseling necessary will be dictated by the results of the screening and the phone interaction with the member.

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**C.7. Provide the paper version and screen shots of the online version of the health questionnaire that you propose to use under this Contract (and the current Flesch-Kincaid reading level of the questionnaire). You may also include an HTML version of your online health questionnaire by storing it on a writeable CD-R and including it with your technical proposal.**

Please refer to **Exhibit W** to review a paper version of our Health Questionnaire and **Exhibit X** to review screen shots of the online version. The overall reading level of the Health Questionnaire is delivered at a 6<sup>th</sup> grade reading level.

**Also, describe the following:**

**(a) The estimated average time that it takes a member to complete the questionnaire;**

The estimated average Health Questionnaire completion time is eleven (11) minutes.

**(b) The process that you used to determine or establish content validity and measure the reliability\* of the health questionnaire; and**

The validity of the Health Questionnaire is derived directly from academic medicine curricula for physician/patient questioning in technique, sequence, and content. EDoc4U's *smart user* interface methodology is a technique using branching logic to ask broad questions first, and then narrow (i.e. get more member specific) as more data is input by the member. In traditional validity testing, health care end users have been shown to respond most accurately to medical sequence testing. As such, we follow this order in our questioning. Finally, the content questioning sections themselves follow the "*language of clinicians*" starting with demographics and medical history, proceeding to family history and medications, and then social and screening sections. These content sections have been shown to ensure internal testing validity among diverse users.

**(c) The distinguishing strengths and comparative advantages of your health questionnaire.**

The eDoc4u Technology was created by its medical advisory team. A group of board certified internal medicine physicians who specialize in disease management and preventive care. The eDoc4u platform is a comprehensive, easy to use, medical web service that presents members with personalized risks for diseases, specific prevention recommendations, culturally competent 'trusted physician' video counseling, integrated personal health record and on-line

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health coaching. eDoc4u impacts population health by empowering, educating and motivating members to take action and improve their health and safety.

eDoc4u's intuitive Health Questionnaire utilizes "*branching logic*" by creating a unique clinical pathway for each member. Self-reported information is captured by our "smart browser interface" during a 10-11 minute on-line member session as well as physician updates and real-time client data transfer. eDoc4u's Health Questionnaire interactively integrates member medical risks and biometrics with lifestyle, mental health and injury prevention. The Health Questionnaire can also be customized for specific client requirements. Current Health Questionnaire variables include; age, gender, ethnicity, personal and family health history, medications, allergies, biometric, screening test history, nutrition, physical activity, readiness to change, substance use, mental health and injury risks. Biometric and clinical laboratory values are evaluated in conjunction with screenings.

APS' program is based on what internal medicine physicians call "*hard prevention*," complete with actionable next steps so the member can both fully comprehend and directly accomplish the screening. eDoc4u's medical algorithms are based on a clinical foundation emanating from the real practice of preventive care by our medical advisory team – each of whom are board certified, maintain an active practice, and achieved the top 5% in their certification scores.

**Please reference (and include, if possible) any peer-reviewed publications in which this health questionnaire featured prominently as a data collection tool.**

**In addition, describe the process and timeframes for making any State-requested customizations or changes to the health questionnaire and your ability to comply with or exceed the flexibility requirements in Contact Section A.4.b.**

The Health Questionnaire can be customized per client and clinical review. Questions and Disease Prevention Recommendation and Disease Risk Index logic extensions can be created to interpret new data points. The timeline to address Health Questionnaire and related logic abstractions will be assessed based on the scope of the changes and within the State's contractually required timeframe. In **Exhibit AA**, we have included a peer-reviewed report conducted by Jeff Andrews, MD, FRCSC, Associate Professor at Vanderbilt University Medical Center that validated the Health Questionnaire.

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**C.8. Describe how, under this Contract, you will provide feedback to the member upon completion of the health questionnaire. Provide summaries of your process for both online and paper questionnaires. Additionally, provide any education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece).**

Upon completion of the online Health Questionnaire, the member is immediately presented with a unique and highly personalized, culturally sensitive and easy-to-understand Preventive Care Plan. Within the Preventive Care Plan the Disease Risk Index is presented. This includes the presentation of risk scores of high, medium and low along a color spectrum for each of our 16 analyzed chronic diseases. These scores allow members a quick assessment of critical focus areas. eDoc4u's patent pending Disease Risk Index (DRI) algorithms are a comprehensive risk evaluation for coronary artery disease, diabetes, high blood pressure, stroke, obesity, depression, asthma, colon cancer, breast cancer, cervical cancer, prostate cancer, testicular cancer, peripheral vascular disease, sleep disorder, ovarian cancer and metabolic syndrome. Each of its 16 DRI's is based on age, gender, ethnicity and peer comparison of over 400 unique data points.

Both the online and paper Health Questionnaire result in the same summaries of our Preventive Care Plan. Paper Health Questionnaire's are entered manually into the online Health Questionnaire. Turnaround time for Health Questionnaire results are dependant only upon the time needed to enter data and responses to the Health Questionnaire. The Preventive Care Plan is delivered at a 6<sup>th</sup> grade reading level (see **Exhibit X** for a sample Preventive Care Plan).

Regardless of risk level, we will provide 100% follow-up. EVERY member who completes the Health Questionnaire will be outreached to via phone to review their results and ensure appropriate follow up. All Health Questionnaire data is uploaded into our health management system platform – APS CareConnection® – facilitating the availability of information at Coaches, Health Promotion Coordinators, Provider Liaisons and Member Service staffs' fingertips. This enables our staff to make the most of each and every member interaction.

**C.9. Describe how, for this Contract, you will develop a wellness score/risk assessment for each member. In particular:**

**(a) Describe the factors used in the scoring, the relative weights associated with each factor (or member response), and both the wellness/risk categories and proposed thresholds for intervention; and**

APS will evaluate information from a number of sources to develop an aggregate wellness score/risk assessment for each State member. These sources – claims analysis, health

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questionnaire, health (biometric ) screening results, and Health Coach assessments – consider various factors that influence an individual's health from his/her lifestyle choices to lack of condition-specific procedures, to how healthcare is utilized, to his/her psychosocial issues and support systems. All factors and interventions are based upon and weighted according to evidence-based guidelines for each condition covered as well as preventive care best practices. APS will apply its scoring methodology using information from these sources as it is received (e.g., we may receive health questionnaire data on some members who do not have any claims data). Our process does not wait for additional information as each member is scored based upon available member data; however, scores are re-evaluated with the addition of all new information. We have outlined our wellness score/risk assessment methodology including weighting or hierarchy below based upon our three data sources:

1. **Claims Analysis:** The primary data source that contributes to the member's wellness score/risk assessment results from the analysis of the State's claims data. Through APS' suite of proprietary informatics tools, an analysis of the State's claims data (medical, behavioral and pharmacy) is conducted to assess the health status of individuals in the State's membership.
  - a. During this process, APS performs a population analysis using stratification methodology based on the disease, behavior utilization patterns, claims, and pharmacy information. The initial stratification process using our proprietary predictive modeling process will identify each member's risk level and assign a primary disease state as well as provide a risk level such as high, moderate, or low.
  - b. The second analysis is used to identify gaps in care such as the Care/Treatment Gap Analysis. Through this process, APS is able to identify members that may be missing recommended standards of care for their identified conditions (e.g., a diabetic who may not have had an A1C test and LDL-C or an asthmatic who is not currently taking an inhaled corticosteroid). This analysis begins to set up actionable triggers that are weighted to provide the Health Coaching team with targeted interventions to assist with coordination and education.
  - c. The third part of the analysis performed is the Uncoordinated Care Behavior analysis. This analysis will begin to identify unnecessary or inappropriate use of care based in the Prevention Quality indicators (PQI). Examples of uncoordinated care include non-emergent Emergency Room use, re-admissions to the hospital, polypharmacy and Medication Possession Ratios.

Through these three proprietary, criteria-driven algorithms, each member is assigned a Total Risk Score (TRS) which is then viewed by a Lifestyle Management Health Coach, Health Coach or Case Manager within the dashboard of APS CareConnection. Additionally, we are able to identify actionable members, or those with behaviors or

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barriers that are the most impactable and place a member at greatest risk of future diagnosis/chronic illness and uncoordinated care. Our analysis suite provides our Health Coaching team with daily prioritization for outreach and contacts.

2. **Health Questionnaire & Health Screening Analysis:** The second source of the member's wellness score/risk assessment results from the member's Health Questionnaire and Health Screening. The Health Questionnaire captures information on the member's history, applicable health screening results (e.g., cholesterol, blood sugar), their behaviors and lifestyle (level of fitness, tobacco use, stress, nutrition) as well as their perception of their overall health. **The Health Questionnaire employs a Disease Risk Index (DRI) that categorizes the member into LOW, MEDIUM, or HIGH risk for a given disease entity (i.e. heart disease or diabetes).** Current DRIs each have risk values which can be 'scored' to then determine an overall wellness value for each member. This information is then loaded into APS CareConnection, and viewable by a Lifestyle Management Health Coach, Health Coach and Case Manager.
3. **One-on-One Assessments:** Although our claims-based predictive modeling and the Health Questionnaire provide an initial indication of the member's wellness score/risk score, a one-on-one interaction by our Health Coach is able to confirm or adjust this assessment. APS Health Coaches gather a more detailed assessment and begin recording member interactions into APS CareConnection®. APS CareConnection® is predicated on national guidelines and the Health Outcomes Institute, a recognized leader in the process of outcomes management. APS Health Coaches will contact 100% of members who complete the Health Questionnaire, a Health Screening or attend an onsite activity to complete this one-on-one assessment.

From these three sources, APS' proprietary algorithms develop a composite risk score that is applied to the member. Our first and primary source of the member's wellness score/risk assessment is claims bases; this score is then adjusted based upon the individual's results of his/her health questionnaire and health screening. For example, a member who has claims data may receive a TRS score of LOW. If the member completes his/her health questionnaire and health screening and receives a HIGH score, the member's overall wellness score/risk assessment would adjust and move the member's score up to a higher risk tier (MODERATE). If an individual does not have claims information, but has taken his/her health questionnaire and health screening, the member's wellness score will be based on the latter, and adjusted as he/she utilizes services that would appear in claims data.

As each member is scored using the available member data and loaded into APS CareConnection, the member is placed into the outreach list using the assigned scores (LOW, MODERATE and HIGH) that identifies and prioritizes immediate outreach by a member of the Health Coaching team. Typically, members identified as LOW score are contacted every other month (at least one interactive contact every two months) to discuss care plan goals and

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activities; those with a MODERATE score are contacted on average at least once a month (at least one interactive contact every month) and those with a HIGH score are contacted at least once a week (at least one interactive contact every week) on average.

At the time of engagement, a Health Coach/Health Educator from the member's designated Health Team will reach out to the member to conduct a more comprehensive assessment to obtain an acuity score. This includes confirming the results of the Health Questionnaire if he/she has completed the Health Questionnaire. This assessment information is entered directly into our web-based, HIPAA compliant, health management system, APS CareConnection® - as a result, all assessment information, claims, health questionnaire, and health screening is viewable by a Lifestyle Management Health Coach, Health Coach and Case Manager. This initial assessment process begins to form the basis for the member's plan of care. During the assessment, APS Health Coaches focus on the "whole person," delving beyond their immediate needs and assessing their potential physical and psychosocial/mental health care needs. We recognize that a "cookie cutter" approach to care management is not effective because each member is uniquely different in terms of the way they view their circumstances, needs, condition, the resources available to them, the way they learn, the way information is processed and how they respond to assistance in seeking health care.

Our comprehensive approach involves an evaluation of all available information described above to determine a wellness /risk assessment score for each identified member. Based upon the availability of data from these data sources, APS will develop an aggregate wellness/risk score for the member. The score considers the member's utilization history (claims data) Total Risk Score (TRS) score, the member's perception of his/her health (Health Questionnaire) as well as the assessment results. The wellness /risk score then determines the type of interventions as well as the frequency of interactions our staff will have with the member.

Key to our approach is our Percolator<sup>SM</sup> process referenced above. Once a State member is identified via claims analysis, completion of the health questionnaire or completion of the health screening, APS uses our Percolator<sup>SM</sup> process to prioritize outreach efforts to target real-time disease management of high risk members with whom we can make the greatest impact – both clinically and financially. Through analyzing multiple data sources, we are able to obtain as much real-time data as possible to inform our decisions and outreach. By running this analytic process daily, APS is able to continually reprioritize members in the outreach list. This outreach list is included in CareConnection through system alerts to Lifestyle Management Health Coaches, Health Coaches and Case Managers. This provides our staff with a daily list of individuals to reach out to based on the highest priority member and provide the most appropriate interventions based on the rules/triggers.

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APS has outlined our intervention thresholds based upon an individual's aggregate wellness score/risk assessment:

**All members** receive basic information and access to:

- Direct mail, IVR and onsite promotion and preventive messaging
- Worksite-based face to face outreach
- Online wellness / prevention management programs
- Assessment and coaching for those members completing a health questionnaire, a health screening, or participating in another onsite event.

**Low risk members** receive:

- Guidance toward a Medical Home
- Direct mail, IVR and onsite promotion and preventive messaging
- Worksite-based face to face outreach via Regional Health Team
- Disease management (telephonic outreach)
- Online wellness / prevention management programs
- Coaching via Health Coach
- Generally touched 6-8 times per year but will receive one interactive contact every other month at a minimum

**Moderate risk members** receive:

- Guidance toward a Medical Home
- Disease management (telephonic outreach)
- Direct mail, IVR and onsite promotion and preventive messaging
- Worksite-based face to face outreach via Regional Health Team
- Online wellness / prevention management programs
- Coaching via Health Coach
- Generally touched 12 times per year but will receive one interactive contact every other month at a minimum

**Highest risk members** or those with complex conditions get most intensive support:

- Guidance toward a Medical Home
- Case management (telephonic outreach)
- Direct mail, IVR and onsite promotion and preventive messaging
- Worksite-based face to face outreach via Regional Health Team
- Online wellness / prevention management programs
- Coaching via Health Coach (telephonic/in-person)
- Generally touched 48 - 60 times per year including at Medical Home but will receive one interactive contact on an average of once a week

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- Remote health monitoring technology that collects and transmits important and timely information data about a member's chronic condition.

### **(b) Detail the challenges associated with making changes to the methodology and the steps you will take to address any challenges.**

APS' methodology for developing a wellness score/risk assessment as described above is currently in place today for our contract with the State of Ohio. Given its current application, we do not anticipate needing any changes to our methodology. However, we understand that the State reserves the right to review the methodology and make changes, and APS is happy to work with the State to do so. In this situation, adjusting risk level thresholds (high/moderate/low) within our methodology to expand or contract the populations found in each level would be a minor change; however, adopting new informatics tools to assess risk for example would be a more significant change. With regard to the Health Questionnaire, the DRI can be customized to the State, and DRI logic extensions can be created to interpret new data points. We will work with the State to identify and resolve any issues with our methodology at your request.

**Please explain how your assessment methodology would "score" the following individuals. To the extent that you need to make assumptions, please do so and state these assumptions in your response.**

- 1. Jane, a 29-year-old pregnant female full-time employee in Murfreesboro, Tennessee with no known medical conditions who self-reports that she uses tobacco;**

Jane was identified through the claims identification process as pregnant with a TRS score of LOW due to her age and having no other clinical issues. The APS Health Coach designated to Jane's region will reach out to her within five (5) business days from when she was identified to assess her maternal/fetal risk as well as additional lifestyle risk factors. During the initial call, the Health Coach will introduce Jane to the program and complete a telephonic maternal/fetal risk assessment. The Health Coach will also obtain Jane's obstetrician/physician name for outreach and obtain physician input into Jane's plan of care with her consent.

Prior to the phone call, Jane also completed her Health Questionnaire and stated that she smoked one (1) pack of cigarettes per day. Our proprietary risk analysis application re-scored Jane's overall score using this new information and identified her as MODERATE Risk. During the initial call, Jane and the Health Coach will complete an initial overview assessment, verify her pregnancy and complete the maternity assessment with Jane telephonically. During the assessment process the Health Coach discovers the pregnancy was unplanned and confirmed that Jane is a smoker, currently smoking one (1) pack of cigarettes per day as stated on her

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Health Questionnaire. Based on the Total risk score and clinical assessment, the Health Coach would determine Jane's overall acuity level and enter the acuity level into APS CareConnection. Because Jane is a current smoker but has no other known risk factors, has not been given a diagnosis of high risk pregnancy, is under the age of 35, and is seeing her OB/GYN, her acuity level would be a 3, or MODERATE risk. Jane would be placed into the Lifestyle management program and contacted at least monthly with smoking cessation education and support.

The most significant concern for Jane and her fetus is to stop smoking due to the high risk of premature labor, low birth weight, and potential for birth defects. The Health Coach will continue to assess Jane's severity of tobacco use, environment enablers, barriers to quitting, and if there were any techniques employed to quit previously.

Using the Readiness to Change model, the Health Coach will be able to identify her stage of receptivity to quitting tobacco in order to meet Jane where she is. Using this model, the Health Coach will be able to tailor the education and focus on Jane's stage of readiness. At this time the Health Coach will also encourage Jane to complete her health screening either via her obstetrician or at a health screening event.

### **2. Ezekial, a 59-year-old male retiree in Union City, Tennessee who indicates depressed mood for at least two months in duration and whose body mass index (37) indicates that he is morbidly obese; and**

Ezekial was identified based on his health questionnaire completion. The APS Health Coach designated to Ezekial's region will reach out to him within seven (7) business days of APS receiving his health questionnaire results. Based on minimal claims data he has not seen his primary care provider in over 12 months and he has had two ER visits in the last 90 days for back pain, giving him a TRS score of moderate risk. Based on his health questionnaire data, Ezekiel has answered the weight and height questions which resulted in a BMI of 37, which is morbidly obese. His answers also demonstrated he has had a depressed mood, and has been consuming more alcohol than is recommended, four to six beers per night. With this information his health questionnaire placed him at a HIGH risk. During the outreach call with the Case Manager they complete the one on one assessments. The Case Manager has identified his depression risk based Ezekial answering positively to the PHQ-2 depression screening, answering positively to the four question CAGE alcohol assessment, his lack of a PCP or medical home, and his ER use for his back pain.

Based on the lack of biometric screening data, the behavioral health issues, back pain, and lack of primary care physician, the Case Manager assigns Ezekial to a level of HIGH risk requiring case management and monitoring focusing on his depressed mood and coordinating a primary medical home.

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The most significant concern for Ezekial is to first address his mood risks based on the positive answers on the PHQ-9 screening tool. The Case Manager will complete the PHQ-9 as untreated major depressive disorder has been shown to negatively impact overall health status. The PHQ-9 is a brief depression questionnaire used to diagnose depression, which results in a severity score to help select and monitor treatment. We have outlined the severity score/provisional diagnosis chart below<sup>1</sup>:

PHQ-9 Score	Provisional Diagnosis
5-9	<b>Minimal Symptoms</b>
10-14	<b>Minor depression</b> <b>Dysthymia</b>
15-19	<b>Major depression, mild</b> <b>Major depression, moderately severe</b>
≥ 20	<b>Major depression, severe</b>

Based on Ezekial's responses to the PHQ-9, he scored high on the PHQ-9 with a score of 16. His Case Manager has identified that Ezekial may require interventions of a behavioral health provider and will obtain Ezekial's primary care physician's (PCP's) name during the initial assessment process and inform him that we will be working with both the PCP and Ezekial to coordinate additional services as well as facilitate and coordinate a PCP visit.

His Case Manager will also perform a community based assessment focusing on barriers to care for Ezekial such as lack of primary care or behavioral health services, transportation, or medication adherence and to initiate specific care coordination activities with the focus being coordination of the most basic needs. The rationale behind the care coordination and creating a supportive environment is to allow Ezekial to have his psychosocial needs met prior to moving immediately into education and goal setting. The process focuses on building self-efficacy and with each accomplished coordination step, such as scheduling an appointment for evaluation of depression, Ezekial will eventually be able to transition to the next step and turn his focus to education, nutrition, exercise, and self management skill building.

Based on the completion of the two initial assessments, a recommended plan of care is generated including at least monthly contacts. Together Ezekial and the Case Manager can tailor the problems/goals and interventions to specifically meet Ezekial's most immediate needs.

<sup>1</sup> [http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/score\\_table](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/score_table). May 25, 2010

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Reminders are put into APS CareConnection to complete the PHQ-9 again within three (3) months as well as focused coordination intervention reminders based on the completion of the community based assessment findings.

During the coaching program and, after working with Ezekial and providing aggressive care coordination over the course of three (3) months, Ezekial has had two (2) visits with a behavioral health provider and is taking an antidepressant. The PHQ-9 is repeated and Ezekial's score is now a 10. Based on his score it is recommended that Ezekial remain on his medication as well as continue with counseling. Ezekial is then transitioned into a disease management program.

The clinical indicators report from the National Association of State Mental Health Program Directors Medical Directors Council suggest an elevated BMI is also a contributing factor for premature mortality due to an increased risk of cardiovascular disease and diabetes based on his elevated BMI of 37. Once Ezekial has addressed his depressed mood and is beginning to recognize the root cause of his depression, he will then begin to develop self empowerment. The next step is assessing his medication adherence to ensure Ezekial is adherent to his newly started antidepressant and assessing his weight condition. At this time the Health Coach and Ezekial can begin working towards goals that he feels he will be able to meet such as beginning a walking program. While the goal may be small (e.g., only walking down the driveway and back), with support from his Health Coach and the building of self efficacy, he will begin to start seeing the positive results of his efforts.

### **3. Fleeta, a 40-year-old female spousal dependent in Knoxville, Tennessee of normal height and weight whose biometrics reveal both elevated blood pressure (159/90) and total cholesterol of 239.**

Fleeta was identified as appropriate for the lifestyle management program while completing her biometric screening at a health fair early in the survey period. APS Health Coaches were onsite at this event. The Health Coach was able to discuss Fleeta's abnormal health screening results with her and also helped Fleeta to complete her Health Questionnaire. Fleeta would have a score of MODERATE risk on her health questionnaire as she was not previously taking any medications and was not diagnosed with any cardiac conditions. Fleeta has not seen her primary care physician within the last six (6) months and was unaware of her elevated blood pressure, but did report to the Health Coach that she has been very tired and having headaches. The Health Coach assessed the severity of these findings and encouraged Fleeta to contact her primary care physician based on her symptomatic reports and abnormal blood pressure and cholesterol results. Next the Health Coach introduced Fleeta to the lifestyle management program, verified her contact information, and scheduled a time for the two of them to speak again. All information is entered into the APS CareConnection system to begin

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the assessment process. Because of the opportunity to meet her Health Coach face to face, Fleeta was able to develop a more trusted relationship with her Health Coach.

Based on Fleeta's biometric screening results, the most significant concern is to address her high blood pressure and cholesterol. The Health Coach recognizes these as precursors to metabolic syndrome (pre-diabetes), which may already be present.

Within seven (7) days, the Health Coach contacts Fleeta for their appointment and completes the initial general assessment and the cholesterol/hypertension assessments. At this point, Fleeta would be scored as MODERATE due to the results of her one-on-one assessment. At this time Fleeta informs the Health Coach that because of the health screening results and their discussion at the onsite event she contacted her physician immediately and has just begun an antihypertensive and a statin for cholesterol. She also informs the Health Coach that since she has a family history of hypertension, her doctor has recommended lifestyle changes such as exercise and dietary changes.

With an assessment-generated plan of care in place, the Health Coach will begin working with Fleeta to help her make the required lifestyle and dietary changes necessary to achieve her goals. This includes monitoring her compliance to the recommended LDL-C testing and BP tests by reviewing her claims data within APS CareConnection®, Fleeta's self reported information, and having auto generated alerts based on gaps in care via Percolator<sup>SM</sup> triggers. By helping her obtain goals such as reporting blood pressure results that are within the recommended range at each phone call and reporting the recommended frequency of LDL-C testing, Fleeta will continue to be contacted and provided with support and education at a minimum of bi-monthly telephonic contacts.

**Also, explain if and how you would ascertain that each of these three members (i) has type II diabetes; (ii) has had a heart attack in the preceding three years or (iii) has a history of lower back pain and is currently considering back surgery.**

APS' Health Management & Wellness program is designed to capture and document a wealth of clinical and lifestyle information on each State member who completes a health questionnaire, health screening or is identified for enrollment in our disease and case management services. We use a combination of historical claims analysis, one-on-one assessments via seasoned clinical staff, health screenings and self-reported information via the health questionnaire to identify a member's current and previous condition(s) by analyzing treatments/procedures, and general medical history. Our care management platform represents a single source of information that houses all relevant health management tools, which include data, clinical guidelines and criteria, individual plans of care, health status assessments, member and provider communications as well as member interventions in a

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single platform accessible to all members, providers and APS clinical staff. Each of these sources is described in greater detail below.

## **Claims and System Generated**

Based on the claims identification and regular updating of APS CareConnection, the Health Coach will be able to visualize a rolling 15 months worth of prescriptions filled, diagnosis codes, and procedures. Based on that information the Health Coach will be able to identify any new refill patterns, procedures, or diagnosis codes such as type II Diabetes and review this information with the member. APS can also create triggers within our Percolator<sup>SM</sup> tool to capture conditions or healthcare events that have occurred prior to the 15 month period (e.g., a trigger based upon a rolling 36 month period to capture a heart attack in the preceding three (3) years.

APS CareConnection offers a systematic interface with all data sources including inputs from our call center, field based staff, physician practice management systems and Plan data sources. With the ability to seamlessly integrate eligibility data, clinical claims, encounter claims, pharmacy claims, as well as information gathered from members and providers, quality improvement efforts and any supplemental data we receive, APS maintains comprehensive information on each eligible member from detailed historical utilization data to documentation of every contact that we make with the member.

## **Health Questionnaire**

Based on the three scenarios above, each of these specific queries for diabetes, heart attack, and low back pain would arise in the branching logic of the Health Questionnaire. The Health Questionnaire analyzes each member for 16 major chronic diseases and presents unique risk scores of high, medium and low along a color spectrum for each. These scores provide members with a quick assessment of critical focus areas. eDoc4u's patent pending Disease Risk Index (DRI) algorithms are a comprehensive risk evaluation for coronary artery disease, diabetes, high blood pressure, stroke, obesity, depression, asthma, colon cancer, breast cancer, cervical cancer, prostate cancer, testicular cancer, peripheral vascular disease, sleep disorder, ovarian cancer and metabolic syndrome. Each of the 16 DRI's is based on age, gender, ethnicity and peer comparison of over 400 unique data points.

## **Specialized Assessment and Skill-Set Training and Education**

The APS Health Coaches are provided with a rigorous training period as well as continuing education programs through APS' training department to identify risk factors for type II diabetes as well as conduct their assessments using a motivational interviewing approach to elicit a dialogue rather than a questionnaire approach. Our initial general assessment provides a broad overview of patient identified conditions such as low back pain, cardiac conditions, diabetes, ER utilization, BMI, PHQ-2, as well as an overview of past medical history,

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medications, and physician contact information. Based on this training, the Health Coaches are trained to review the clinical data, health questionnaire data, and biometric data to identify potential risks for chronic disease or those with chronic disease with gaps in care as provided by our Percolator<sup>SM</sup> triggers. Examples of our Percolator<sup>SM</sup> triggers follow.

The three scenarios above would be identified as having or being at risk for type II diabetes, having a heart attack or a history of low back pain by the following:

Every member will be screened for these conditions based on the following criteria:

### Type II diabetes utilizing all data sources:

1. Through the diagnostic information on medical claims such as ICD9 codes 250, 357.2, etc.
2. Identification from prescription drug claims such as insulin or oral hypoglycemic medications
3. Health questionnaire
4. Health screening data showing a fasting glucose of > 100
5. Health Coach assessment/self reported

### Myocardial Infarction or at risk cardiac screening would involve:

1. An identification through medical claims such as ICD9 410, 410, etc
2. An identification from prescription drug claims such as beta blockers, which are a recommended practice for those post MI
3. Health questionnaire
4. Health Coach assessment/self reported

### Low back pain or low back pain disorders would identify using:

1. An identification through medical claims such as ICD9 353.1, 353.4, 721.3, 722.1, etc
2. Health questionnaire
3. Health Coach assessment/self reported

With the ability to identify the potential for chronic illness or disease exacerbation using a multi modal approach we would be able to identify Ezekial may have had a heart attack 3 years ago based on his medication refill patterns. Ezekial had previously acquired and filled a prescription for a beta blocker two and a half years ago for approximately four months duration, with no additional refills. Knowing beta blockers are recommended for a post MI patient; our system

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has triggers in place to identify this as a potential care gap for the Case Manager to address with the member during an assessment to gather additional information and provide education and support interventions.

Ezekial also had two recent ER claims for low back pain. Claims identification alone would require further assessment to review his discharge instructions from his ER visits as well as his past medical history around his low back pain. Based on the assessment findings, he has not had appropriate diagnostic testing performed and was referred to an orthopedic specialist by the ER physician. Based on this information, the Case Manager would still refer the member to his PCP and assist with coordination to create an integrated approach between the physician and the specialist.

To identify a member for type II diabetes claims analysis would demonstrate use of diabetic medications, as well as an HbA1c. The member may also be identified via the health questionnaire and reports they are type II diabetic but are managing with diet and exercise; therefore they may not have any reported claims for medications and may only have an annual HbA1c. Fleeta may self report during a Health Coaching assessment that she was diagnosed with type II diabetes; however she is managing her blood sugar with lifestyle changes such as diet and exercise. Her care manager would supply her with diabetes education and ongoing monitoring would continue to identify her for more intensive services with continued focus on her hypertension and hyperlipidemia.

**Please also specify the extent to which you will also use medical claims data. Describe the specific types of data that you will require and your expectations of both the State and the State's Decision Support Services vendor to provide these data to you. Please note: The State is unlikely to approve any approach that involves direct claims feeds from the medical third party administrators (rather than from the Decision Support Services vendor).**

APS prefers to receive as much claims data as possible each month via SFTP to conduct our analysis, which includes medical claims, behavioral health claims and pharmacy claims, with admission/authorization data. As stated above, APS will use medical, behavioral and pharmacy claims data received from the State's DSS vendor, Thomson Reuters, on a monthly basis as one factor in determining an overall wellness/risk scores for members. APS already has a working relationship with Thomson Reuters for other clients and we will work collaboratively with them to establish an effective data interface for importing claims data through a secure means (e.g., SFTP) using a HIPAA compliant format on behalf of the State.

APS' Health Management & Wellness efforts are driven by a state of the art identification and stratification process via informatics tools that identifies members by assigning a sophisticated risk score to every member. Based upon this risk score along with other factors such as the

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health questionnaire, health screening results, and the assessment of the Wellness/Health Coach, APS identifies opportunities for intervention and ranks them by priority, which improves our ability to make measurable changes and then track them for the State. We also use a comprehensive data set to search for gaps in care, compliance issues, under and over use of healthcare services, and over 3,000 clinical rules that establish a benchmark for our Lifestyle Management Health Coach, Health Coaches and Health Promotion Coordinators to assist the State's members.

## **Claims Analysis via Informatics Tools**

APS' comprehensive suite of proprietary and licensed informatics tools include the Johns Hopkins Adjusted Clinical Groups (ACGs) Case-Mix System, Predictive Modeling and our proprietary Treatment Gap Analysis informatics tool. These tools identify and assess the health status of each client's population, stratify the population by risk for outreach and intervention as well as report on clinical gaps in care. This information is integrated into our web-based APS CareConnection®, system where we capture and maintain individual member information, enabling us to report on various program activities such as participation rates and outcome measures. Specifically, application of our state-of-the-art informatics tools enables APS to:

- Identify individuals who have a history of treatment for a particular condition or have been recently diagnosed;
- Identify individuals at risk, who may not be identifiable using only clinical information, enabling us to provide preventive, proactive care management services;
- Stratify identified individuals into risk categories (Low, Moderate and High); and
- Identify non-compliance with recommended treatment guidelines.

As part of our data analytics process, we will use the following tools to assess the health status of the State's membership:

- Johns Hopkins' Case-Mix System:
  - Identifies high-cost cases and defines illness burden
  - Stratifies by risk
  - Identifies presence of co-morbid health conditions
- APS Proprietary Predictive Modeling:
  - Identifies specific utilization and cost drivers, i.e., what specific disease states are driving costs
- APS Proprietary Treatment Gap Analysis:
  - Identifies treatment gaps between national best practices and current treatment

Together with industry expertise and analytical rigor, these tools and technologies can deliver applicable and actionable information to the State. The value we offer to the State is that our

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sophisticated informatics capabilities and consulting services will empower you to better understand the impact of certain conditions on health care and utilization for your programs; and our analyses will assist you in making informed decisions about the planning, implementation and administration of your Health Management & Wellness program.

**In addition, describe the process and timeframes for making any State-requested changes to your methodology and your ability to comply with or exceed the flexibility requirements in Contract Sections A.5.h. and A.5.j.**

In accordance with Contract Sections A.5.h and A.5.j, APS confirms that we will submit our methodology for developing the wellness score and determining wellness/risk categories, including but not limited to, the factors used in the scoring, how those factors are weighted, the wellness/risk categories, the threshold for those categories, and the threshold for each program/type of intervention to the State for approval on or before September 1, 2010. APS understands the State reserves the right to review the methodology and require changes, and is flexible in terms of making such changes. APS will work closely with the State during the implementation process to review our proposed methodology, answer questions, make changes per the State's request, and receive final approval once changes have been made. Your dedicated Account Manager in partnership with all applicable subject matter experts (e.g., Clinical Product Development, Health Intelligence, etc.) will be responsible for spearheading this process and ensuring your satisfaction with the final methodology. APS also confirms that APS will modify our wellness score/risk assessment process within thirty (30) days of the State's request.

**C.10. Given that members could complete the health questionnaire before or after the health screening, describe the type of feedback you will provide and the way in which you will deliver it to communicate your holistic assessment of a member's health risks under this Contract. Explain how this larger communication relates to the post-screening and post-questionnaire information and materials that you will have provided. Additionally, provide any education materials that you propose to use for this purpose (and the current Flesch-Kincaid reading level of each piece). Finally, explain what follow-up and reminder contacts you will make to members who registered by February 14 but who have not completed either or both the health questionnaire or health screening.**

Regardless of whether the member completes the health questionnaire or health screening first, the member will receive outreach from an APS Health Coach. The Health Coach will review the results of either screening and determine if the individual would be an appropriate candidate for a specific lifestyle, disease management or case management program. The

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Health Coach will also encourage the member to receive the additional required screening to satisfy their obligations under the Partnership Promise. The Health Coach will inform the member of all of the material available to him/her online and via other formats.

Upon completion of the Health Questionnaire eDoc4u immediately presents the members' Preventive Care Plan. eDoc4u will present robust email invitation and email reminder messaging to the member at defined intervals to encourage short and long term engagement of the Disease Prevention services. This is part of the broader communication program to constantly make members aware of the resources available to them through the program.

APS will review the members who have completed the online registration by February 14<sup>th</sup> but have not completed either or both of the screenings. We will send regular emails and/or automated outbound telephonic messaging to identified individuals with reminders to complete the remaining screening to comply with their Partnership Promise and maintain the high level of benefit available.

A sample promise reminder, which is written at a 6<sup>th</sup> grade reading level, is provided in **Exhibit N**.

**C.11. Describe your process, for this Contract, for enrolling members in lifestyle management, disease management, and case management, including the method, frequency, and timeframes for engagement and whether this varies by condition, member risk, or other methodology.**

APS program for the State will be delivered using a population-based approach to health management inclusive of a health risk appraisal to assist in identifying modifiable health risks and an integrated wellness and disease management program, utilizing onsite, online and telephonic programs designed to empower individuals to positively alter their health behavior over the long term. We will establish a local office and staff it with personnel hired from within the state who understand the local culture and geography. As part of our program, we are committed to providing a robust "*face to face capacity*" for outreach and engagement throughout the State of Tennessee. Our community-based, regional care staff and collaborative relationships with community organizations will enhance our ability to engage members, including those who are difficult to reach through the more traditional methods of telephone and mail communications.

We recommend an ongoing campaign to drive awareness and engagement that will include client-specific branding; US Mail, telephonic and online messaging; social networking media; available client intranet resources; and multiple worksite programs. Worksite programs can

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include a variety of topics such as stress, nutrition, exercise, tobacco cessation and weight management as well as finance and legal issues – all areas impacting individual health and productivity. We will engage and involve the State's local leadership to endorse program participation and identify and recruit Site Champions for ongoing promotion.

Member interventions and outreach efforts are tailored to the individual based on risk. Low risk participants will be messaged and directed to engage in the self management tools and programs online to maintain their positive health. Interventions for members with higher risk scores begin with the comprehensive assessment that forms the basis of the individualized Plan of Care (POC). APS recognizes that providers play an active, primary role in determining the best interventions for their patients. As such, we believe that coordination with and support of the provider and other available resources (i.e. home health care, rehab services, etc) are as important as member interactions in achieving coordinated care plans. Our outreach efforts will be inclusive of all entities that support the member.

The member's individualized POC and the recommended interventions that emanate from the POC are person-centered rather than condition-centered. This allows for better coordination and treatment with members who have multiple conditions, rather than relying on arbitrary, outdated and ineffective "*primary disease*" models. Interventions begin by addressing basic needs and extend to medical interventions in a patient-centric, provider-supportive manner. The intensity and frequency of interventions are mapped to the risk strata and percolator status, allowing the APS Health/Lifestyle Management Health Coaches and Case Managers to focus on those interventions that are most likely to reduce future high-cost events while ensuring high quality care.

### Identification of Members

The APS approach to segmenting a population for engagement in lifestyle management, disease management, and case management activities begins with standard industry tools to stratify members by cost and disease/ disease burden based on claims data. APS then applies proprietary models of risk and need (including APS' proprietary Percolator<sup>SM</sup>) to segment these members into their appropriate categories. This information is also supplemented by Health Questionnaire and Health Screening results as they become available. All members in the "green" category (as shown in the chart below) are considered members with low overall risk scores. These members have access to a variety of wellness and health promotion tools (health assessment, online tools and lessons, lifestyle management programs, etc) to maintain their good health. They will also be monitored continuously for change in status.

Other members will be identified as having higher risk scores and characteristics that have been shown to be impactable – e.g., those utilizing multiple providers, those with no established medical home, those with unaddressed psychosocial needs etc. These "yellow" and "red"

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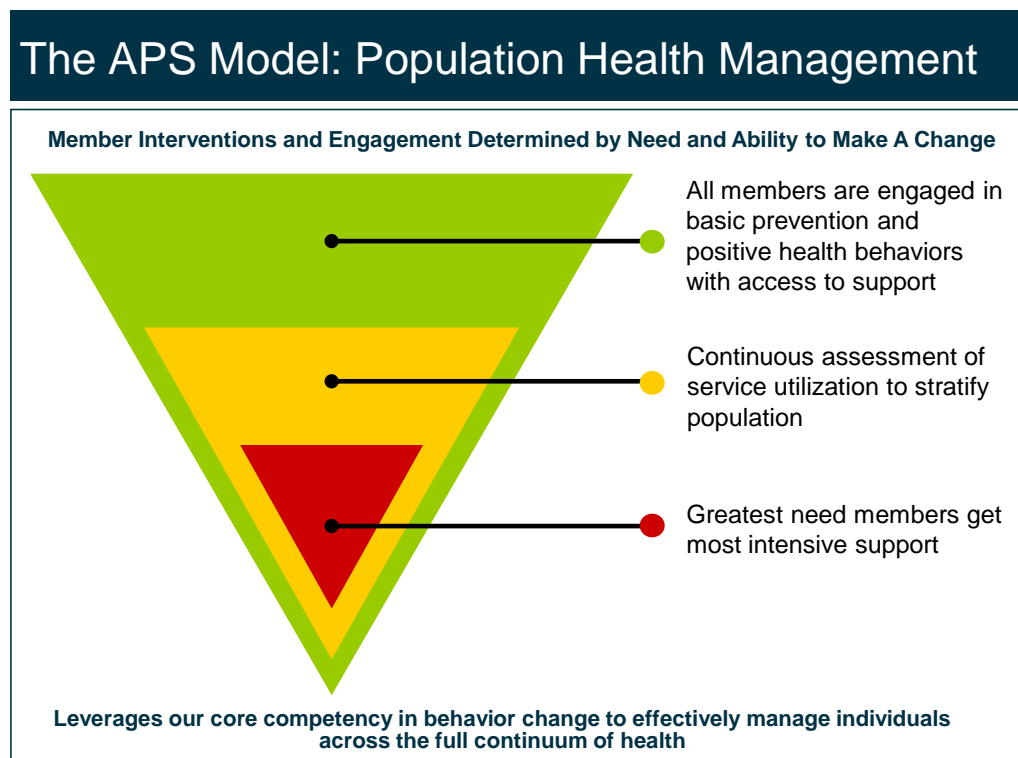
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members (as shown in the chart below) are identified for potentially more intensive interventions such as a disease (condition) management or case management program in addition to the wellness and health promotion tools. This proprietary application, Percolator<sup>SM</sup>, has the added advantage of being linked to staff work flows and the daily prioritization thereof. Data is run through the Percolator<sup>SM</sup> daily.

APS also stratifies providers to identify those with a large numbers of patients in the high cost/high risk group and who demonstrate consistent patterns of unnecessary and costly practice patterns. APS then applies our Percolator<sup>SM</sup> tool in order to prioritize member outreach as well as specific interventions for each member.

Integrating predictive modeling risk scores with clinically-based rules provides an accurate method for targeting coordination efforts and facilitates the allocation of resources to maximize the effectiveness of our health management interventions. APS will conduct an analysis of the State's data to identify, stratify and target individuals for appropriate intervention.

To segment these groups, we utilize a three tier risk stratification approach represented in the diagram below.



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We will establish Health Promotion Coordinators who can be deployed throughout the State at the State's various worksites to meet face to face with the member population at health fairs, health screening events, and brown bag educational presentations.

Our Provider Liaisons will be guided by geographical analyses that identify provider offices where there is a high volume of members. These Liaisons will collaborate with provider offices to obtain updates on member contact information.

Our community-based, regional care staff and collaborative relationships with community organizations will enhance our ability to engage members who are difficult to reach through the more traditional methods of telephone and mail communications.

We refer to this approach of establishing a significant on-the-ground presence and partnerships with community providers as our *Community Health Partnership* model.

### **Low Risk**

APS' proposed program will be delivered via a variety of channels – including direct mail, email, online, telephonically and face to face at the State's worksites throughout the State of Tennessee, depending on the needs of the individual. The face to face worksite services are critical as our understanding and experience dictates that successful healthcare is and should be local.

Based on our experience and success with other health management programs, such as the State of Ohio employees program, to effectively engage members in the program services and encourage participation, APS will telephonically outreach to the State's members who complete a personal Health Questionnaire, complete a health screening and/or attend a brown bag educational presentation. We will conduct outreach to 100% of the State's members who engage in these services.

A Health Coach will outreach to EVERY State member who:

- Participates in an onsite health screening to review their results and ensure appropriate follow up
  - Health screening test results are uploaded into our care management platform – APS CareConnection® - facilitating the availability of information at Lifestyle Management Health Coaches, Health Coaches, Health Promotion Coordinators and Case Managers staffs' fingertips. This enables our staff to make the most of each and every member interaction
- Completes an Health Questionnaire to review their results and ensure appropriate follow up

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- Health Questionnaire results are also uploaded into our care management platform – APS CareConnection® - facilitating the availability of information at Lifestyle Management Health Coaches, Health Coaches, Health Promotion Coordinators and Case Management staffs' fingertips. This enables our staff to make the most of each and every member interaction

Typically, this will be one of the key interactions between Health Coaches and members of the low risk population. For those identified as low risk and in the lifestyle management programs will receive interactive contacts with a Health Coach at least once every other month. Typically, this will occur more frequently at the beginning of the coaching relationship while initial goals are established and met. Beyond this, APS' program for the State includes access for your membership to print, online, telephonic and worksite health promotion, education and self management program services.

The State's members can access our telephonic wellness/lifestyle management coaching and work one-on-one with a Tennessee Lifestyle Management Health Coach as a supplement to the 24/7 online wellness/lifestyle management programs. Members can simply call their toll-free number to speak directly with a Tennessee Lifestyle Management Health Coach for one-on-one wellness/lifestyle management coaching through the State's dedicated toll-free number from 8:00 am to 8 pm CST Monday through Friday. The Health Coach will be able to see all of the activities the member has completed whether done through the self-service on-line tools or via the Coach. All of this information is tracked in CareConnection and allows for a comprehensive view of the member.

### ***Moderate Risk and Disease Management***

Members who are identified as being at moderate risk will also receive outreach. In addition to the strategies employed above, APS will utilize other avenues. We will conduct direct mail, email, online, telephonic and face to face activities at the State's worksites. We will also collaborate with primary care medical home (PCMH) providers to assist in the outreach of these members. These members will engage in interactive contacts with a Health Coach at least once every month. Typically, the contacts are more frequent throughout the relationship and include other members of the coaching team.

### ***High Risk and Case Management***

In addition to the services and interventions provided to those members identified as low and moderate-risk above, high-risk members will receive more frequent telephonic contact from their Primary Health Coach, complex case management support, and linkage to available community services:

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- Patient-centered medical home identification
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of plan of care (in collaboration with member and provider)
- Assist in ensuring compliance with clinical practice guidelines
- 24/7 web-based access to health maintenance and wellness information
- More frequent telephonic contact from their Primary Health Coach which includes complex case management support
- Linkage to available community services
- Ongoing assessment, stratification, monitoring and follow-up
- Physician outreach/involvement

These members will receive more frequent contacts from their Health Coach. They will engage in interactive contacts at least once every month. However, it is typically several times a month even weekly especially during the initial stages of their coaching program.

During the Implementation Period we will discuss possible approaches to engagement with the State and develop strategies that are built upon the unique attributes of the member population. For example, two additional strategies include the following:

- Coordinating with hospital discharge planning: Engaging targeted members at the point of discharge from an inpatient or ER event is an ideal point to ensure the discharge plan is followed by the member and another costly inpatient or ER visit is averted. APS will work to establish referrals from discharge planners, ER nurses, and admissions personnel. We will offer to build linkages which allow for easy referral to APS programs for frequent ER utilizers and clinically qualified hospitalized members who have not been previously engaged. For some of our other programs APS has managed to employ an easy, one-page referral form to facilitate this process. Linkages with hospital discharge planning will also allow our staff to coordinate care across the expanded health care team, to identify conditions of need, any additional educational needs, and to update the member's individualized care plan via APS CareConnection®. We will also continue to build upon our pre-proposal discussion with health system leaders and other key stakeholders to collaborate on outreach and engagement strategies, and foster overall support for the program to provide education and support for program members.
- Engaging Community Pharmacists: Almost every one of the members we will target for disease management or case management programs will be prescribed one or more prescriptions. Pharmacists are trusted healthcare professionals and are routinely in contact with the population which is targeted for the program. APS reaches out to

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pharmacists and enlist their support in reaching members who are difficult to reach by telephone. We will ask the community pharmacist to help make potential members aware of the program.

Our goal is to deliver a comprehensive service that reaches as many members as possible and helps them effectively change their at-risk behaviors and adopt sustained healthy behaviors.

**Explain the specific steps that you will take to ensure that members do not receive multiple, duplicative or uncoordinated contacts from your staff, the medical TPAs, the PBM, and the EAP/BHO regarding the same or similar issues.**

APS CareConnection® acts as a single source of member information to all relevant parties. Every successful and unsuccessful attempt/contact of members is documented by our team in APS CareConnection. APS CareConnection, a HIPPA compliant web-based system, is a sophisticated, integrated care management system that has been successfully implemented in multiple sites and states. One of the most significant benefits to APS CareConnection is that it represents a single source of information that houses all relevant operational activities, communication attempts, interventions provided, care plans, and health status assessments in a single database that is accessible by all APS clinical staff and providers assuring that members do not receive multiple, duplicative or uncoordinated contacts from our staff.

Every time APS receives a claims refresh from the State and the State's identified partners (PBM, EAP...), a client's utilization history is automatically updated. Updated information is accessible to our clinical staff allowing them to update and re-evaluate the health risk status of the member. During every interaction with a member updated information is evaluated based on changes in the severity of the illness/injury or disease and the complexity of the case. Risk stratification is based on the client's total illness burden, ensuring that all factors impacting the member's health are addressed. For every member attempt/contact, the APS staff will document and record this information.

In addition, to ensure our success and meet the State's service integration requirements, APS will employ our proven service integration protocols with the State's external benefit vendors as well as our subcontractor partners to establish a multi-service program that is seamless to members, results in simplified program management for the State, and results in the most person-centered and coordinated care possible for members. As we have years of experience delivering integrated services – inclusive of wellness, disease management, medical/behavioral utilization management, medical/behavioral case management, disability management and employee assistance programs, we have an intimate understanding of how important close coordination is to maintaining high member satisfaction, improving member outcomes as well

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as achieving cost-savings for our customers. As part of the implementation process, APS will meet with the State's key vendors to:

- Educate one another on our respective programs and goals (cross-training).
- Establish cross-referral criteria to ensure each party knows when to refer members to other programs.
- Establish interface protocols (e.g., how to seamlessly refer members to other programs as quickly as possible; developing a *"warm connect"* process to ensure the hand off and care coordination between benefits is transparent to members; coordination of care protocols; follow-up criteria and timeframes).
- Establish effective and efficient data exchange protocols to ensure all of our customers' benefit partners have access to the same clinical information and that all parties can appropriately coordinate services. This involves exchanging data typically via secure FTP at mutually agreed upon timeframes.
- Identify key contacts for complex cases or to resolve issues.

All appropriate contact, benefit, and interface data will then be loaded into APS Care Connection for easy access by our Lifestyle Management Health Coaches, Health Coaches, Case Managers, Health Promotion Coordinators and Provider Liaisons. As a result, if a Health Coach identifies a need for services outside APS' scope but within the member's benefit plan (e.g., medical management services such as transplants or discharge planning, behavioral health services, end stage renal disease care management, etc.) during an assessment or coaching session, they can seamlessly connect the member to the appropriate vendor for assistance and coordination of care. On the other hand, if your EAP vendor identifies that a member is struggling with managing their diabetes during their normal processes, they can refer the member to APS for disease management services. By establishing clear roles and responsibilities, interface protocols, and an overall culture of partnership between all relevant vendors, we are best able to make the greatest clinical impact on the State's members.

APS uses a similar approach with subcontractor partners. For example, we have established effective and efficient data exchange protocols to ensure our subcontractors have HIPPA compliant, role based access to the same clinical information and that all parties can appropriately coordinate services. We have established seamless interface protocols for cross-referrals, coordination of care issues, follow-up criteria, etc. to ensure benefits are transparent to members and that they receive the most appropriate service as quickly as possible. Furthermore, we have identified liaisons within each party to clarify questions, resolve issues quickly and consult on complex/special cases.

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The benefits of our service integration model include:

- Simplified benefit access for members
- Higher levels of member satisfaction with the program
- Holistic approach to care that involves addressing each member's complete healthcare needs regardless of which benefit they choose to access first
- Improved outcomes through enhanced coordination among benefits
- Reduced healthcare costs
- A high degree of benefit integration without losing program specialization
- Decrease in the amount of administrative oversight required by the customer and associated management costs
- Integrated reporting
- More rapid response in terms of effecting program changes

Using an integrated strategy, APS has the ability to identify and intervene early on to make the greatest impact on member outcomes while simultaneously helping customers better manage their healthcare dollars. We believe we can do the same for the State.

APS will also employ our service integration model whereby we position our personnel as the member's Health Advocate. The Health Advocates are intended to facilitate the appropriate coordination and utilization of the State's programs and services across the health continuum.

Our model encourages and enables appropriate use of preventive health care services, health education, disease management programs and case management program services. These resources will provide:

- Assistance in identifying the appropriate program, health education or level of medical care required to effectively address actual or potential health risks or illnesses through the State's programs and/or the member's community
- An understanding of the benefit features/structures under all available health plans
- Education on how to take care of one's self to prevent illnesses/health risks, or effectively manage existing illnesses/health risks
- A multi-disciplinary team of health professionals (clinical and non-clinical) qualified to support clinical, behavioral and administrative activities with a focus on supporting individuals in behavior change and empowerment

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This Health Advocate model will include each of the following core components:

- Dedicated, Live Answer: A dedicated staff specifically trained on the State's benefit design and unique characteristics/offerings of geographic-specific health care communities that may require non-standard advice
- Navigational Advocate: Support members with navigation through the various components of the State's health care programs (helping members find the appropriate program/service)
- Clinical Advocate: Support members in making appropriate care decisions in response to health risk, acute or chronic illness or injury

**Additionally, while the RFP identifies lifestyle management, disease management, and case management as separate programs, the Contractor shall implement these as a continuum of services. Describe how you will accomplish this both internally and with members.**

Under the State's program, your entire team of Lifestyle Management Health Coaches, Health Coaches, Case Managers, Health Promotion Coordinators and Provider Liaisons, will be located not only in our Tennessee Service Center but remote throughout the State, will work together to facilitate ease of communication and coordination of care between our wellness, disease management and case management program components. Coordination is further facilitated through APS Care Connection® and through established protocols as all team members will have access to same the member information. This includes various types of health information (e.g., claims data, Health Questionnaire results, lifestyle management data, health screening data, assessments, interventions, etc.) to assist in the seamless management of the State's members.

Through APS' systems platform, we can effectively integrate health management and wellness information with various types of data necessary to ensure the State's program is a success. Specifically, our systems platform provides a display of shared data that includes: medical and pharmacy claims, Health Questionnaire scores, health screening data, predictive modeling risk scores, chronic conditions, program engagement points, and gaps in care. By integrating this data within APS CareConnection®, our Health Coaches and Case Managers can see a 360 degree view of each member. This improves the teamwork amongst the health management and wellness services, and provides a seamless member experience.

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As a result, the State's team of Health Coaches, Lifestyle Management Health Coaches, Case Managers and other staff will be able to work collaboratively with one another to effectively manage each member's health in the most holistic manner possible.

As a member engages with a Health Coach, he or she will be reaching various goals and milestones depending on the complexity of the condition. As each goal is met, the member is automatically moved on to the next goal by his/her Health Coach. The member simply follows the program which will take him/her through the care continuum with the intended benefit of improving the member's overall health. A member may "graduate" from one program by meeting his/her goals but may still be enrolled in the same program or moved to another depending on the condition.

This movement of members throughout the care continuum is how all APS programs work and is not a new concept to our team members.

**C.12. Describe your proposed staffing model for the coaches and case managers required under this Contract. As part of this description please describe the coach/case manager to member ratios you will use (if any), how you will ensure all coaches and case managers have the appropriate required qualifications and the training you will employ for coaches/case managers. Regarding your process for assigning coaches/case managers under this Contract, describe:**

The strength of APS' health management programs is grounded in the recruitment and training of highly qualified front line personnel who understand the population they serve. The front line staff is guided by experienced and knowledgeable key staff. APS' health management and wellness services program will be led and administered by staff with the range of expertise, such as registered nurses (RN), behavioral health specialists, and licensed social workers to address the specific cultural, ethnic, and social diversity of the eligible population. Front line personnel, including clinical staff, will be recruited from Tennessee to ensure that they understand the local healthcare system, cultural diversity and demographics of the State. This team will be led by key personnel with substantial knowledge of the health management programming and direct experience in administering health management programs.

The Tennessee program will be staffed with a mixture of RN's, call center Health Educators, Social Workers and Health Promotion Coordinators. These individuals will act as a team to support the Tennessee members as they move through the care continuum. A team-based approach will be utilized and case loads will vary greatly depending upon the condition and risk level of the individuals.

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**(a.) How coaches/case managers will be assigned to particular participants, e.g. risk level, condition, geography, and/or other;**

Cases are assigned to staff to ensure that those with medically and socially complex care needs have the support they need. With this team-based approach, members can be served by multiple people within that team to best assist that individual.

APS will staff the State's program with a seasoned team of professionals who are qualified to deliver the finest quality health coaching, disease management and case management services to your membership. The program will include a multi-disciplinary team of Health Coaches, Lifestyle Management Health Coaches, Health Educators as well as Case Managers to ensure we have various types of knowledge staff on hand to assist members regardless of their issues, conditions, etc. – from managing their weight loss to managing their diabetes. Specifically, Health Coaches will be responsible for delivering disease management services including health coaching for various chronic conditions. This includes health coaching for chronic conditions with accompanying wellness issues such as a diabetic who is struggling with quitting smoking and losing weight. Lifestyle Management Health Coaches will be responsible for providing telephonic health coaching to members with wellness or lifestyle management issues such as tobacco cessation, weight management, high cholesterol and hypertension, etc., but who do not have a chronic condition. Additionally, the State's Case Managers will be specifically responsible for providing comprehensive case management services to your members.

We will establish regional care teams who will be deployed throughout the state based upon a combination of targeted client density, high volume providers and Tennessee's unique geography. Team members will also attend onsite screening events occasionally to create as much of a face to face capacity as possible. For the highest risk members, the care team is led by a primary nurse (described as a Health Coach within the proposal response) who is responsible for performing assessments; planning appropriate care; and evaluating the progress of that client throughout his or her engagement in the program, regardless of level or acuity. In this role, the primary nurse also acts as the client's "health advocate," establishing a trusting relationship, assuring complex needs are met and providing for continuity of care within the regional team structure. As a key component of our service model, we establish community partnerships with stakeholders (community clinics, rural hospitals, etc.) to more efficiently extend our service reach to all corners of the state. These partnerships will support your members as they seek and receive care in self identified medical homes. For high volume providers, our provider liaisons will support providers with information on individual members as well as feedback regarding aggregate practice performance on HEDIS metrics such as annual a1c measurements for the practice.

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All Health Coaches and Case Managers are cross trained to ensure each is capable of assisting any member or their provider, regardless of the type of case. If a member has multiple needs, he/she would be assigned to an appropriate Health Coach/Case Manager based on the primary assessed need. The assigned Coach or Manager will then work to coordinate with the rest of the members of the team in holistically managing the member's entire healthcare needs. Additionally, our Lifestyle Management Health Coaches will also be trained on the State's various program components including how to refer a member to either a Health Coach or Case Manager for appropriate services when necessary.

**(b.) At what point in the process individual coaches/case managers will be assigned to a particular member/participant;**

Once an individual has been identified through our analysis of claims, health questionnaire and/or health screenings as eligible for the program, the coach or Case Manager will initiate the attempt to contact the individual. Each individual client is assigned to one Coach or Case Manager and becomes part of his/her member panel in our APS CareConnection® care management system. This assignment creates the ability to send automatic prompts to a specific Coach/Case Manager when a member is overdue for a scheduled outbound call and allows the Clinical Operations Manager to track appropriate caseload distribution.

The assigned Coach or Case Manager will do all proactive outreach with his/her assigned member panel. There may be a time when a member calls in and speaks to a different Coach or Case Manager due to the assigned coach being unavailable (working with another member, time off, etc.). When this happens the interaction is documented and forwarded to the assigned Coach/Case Manager who will review the notes to determine appropriate next steps and outreach.

We assign every high-risk/high-cost member a designated RN Health Coach or Case Manager who works with them one-on-one for the duration of their engagement. As the member's personal "health advocate," the member's assigned Health Coach/Case Manager works collaboratively with the other members of the regional care team.

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The assignment of a client to the same Health Coach for the duration of a member's engagement allows us not only to track appropriate caseloads but also focus on person-centered interventions. Through multiple interactions with the member, the Coach/Case Manager is better able to establish a relationship of trust and focus on the following plan of care objectives:

- Improving care coordination by addressing stable housing and establishing a healthcare home.
- Monitoring: medication adherence, gaps in care, barriers to care (e.g., .transportation).
- Providing education relevant to the client's clinical condition.
- Improving self management skills.

### **(c.) How members with two or more conditions are managed (e.g., single coach/case manager or team);**

APS employs a Primary Coach/Case Manager Model. Under this model, each member is assigned a personal RN Coach/Case Manager who works with them one-on-one. As the member's personal "*health advocate*," the Coach/Case Manager works collaboratively with available resources based upon the member's most pressing need at that time. For example, in addition to registered nurses, APS also employs registered dietitians and fitness trainers. These resources are available in response to the high volume of members who have needs related to either nutrition or exercise. If nutrition is assessed as a co-morbid issue, the participant's RN Coach/Case Manager will facilitate discussions between the member and our registered dietitian.

### **(d.) If you would assign teams to a member, describe when and how this will happen; and**

APS will develop regional care teams that include a spectrum of specialties including social workers, registered nurses, and pharmacists. Via our regional based Provider Liaisons, we will attempt to include providers and/or clinic staff as members of the regional care team. While the final size and number of regional care teams will be based upon analyses and discussions with the State conducted during the Implementation Period, we anticipate that each regional care team will include at a minimum a Provider Liaison, Health Promotion Coordinator, Health Coach and Case Manager. The regional care teams will be supervised by our Clinical Operations Manager with guidance by the Provider Relations Manager. These care teams will work with both members and providers at a community, in-person level. They will also be charged with supporting the medical home model for both members and providers. They will all have access to our APS CareConnection system and will be accountable to reviewing and updating the POC with every interaction. Teams would be assigned to members when they are initially identified

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for a lifestyle, disease or case management program. The Health Coach will contact the member to confirm the need for a program and begin that process. The member would stay with that team as they progress through the care continuum.

The goal of this geographically dispersed and multi-disciplinary composed team is to enhance the PCMH by ensuring the member is supported outside of the clinical setting. By providing physical and mental health providers within the member's care team with actionable information they're not traditionally privy to—such as pharmacy data demonstrating poor adherence to an antipsychotic—we can alert clinical and community services to a member's perceived barriers to taking medications and work to close gaps in care. This example of sharing information and coordinating care can potentially prevent an emergent event.

Our Health Coaches, regional care teams, and participating providers will work together to address issues and barriers like these to ensure members receive and use their medications. In addition to posting APS CareConnection alerts, we notify the client's PCMH of non-adherence issues so our teams together can address barriers to appropriate care.

**(e.) Your process for transitioning members to new coaches/case managers, including changes initiated by the Contractor and by the member.**

APS understands the importance of the health coach/participant relationship. We understand that if that relationship is successful then the participant will be able to sustain positive behavior changes. If that relationship is not successful, then it is a potential lost opportunity to improve health outcomes. Rapport, trust, and respect are key components in the health coach/participant relationship. If the participant is unable to establish such a relationship – we work with them to identify and address the barriers up to and including assigning a new health coach as their health advocate.

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### **C.13. Regarding each of your lifestyle management programs under this Contract for the conditions listed in Contract Section A.7.r., describe or provide the following:**

APS delivers wellness/lifestyle management program services in coordination with our partner eDoc4u. The benefits of the APS/eDoc4u partnership include:

- Comprehensive suite of online programs and tools available 24/7 that complement APS' existing telephonic and onsite wellness/lifestyle management, disease management, case management, health advocacy and worksite program services, enabling us to create a fluid care continuum for clients, such as the State seeking an integrated solution to extend the reach of the programs
- Commonality in expertise and use of behavioral change science to help members make positive health changes for the long-term
- Unique tailoring technology and ability to customize internet communications/health improvement plans to specific members
- A strong track record of documented outcomes
- The ability to offer our clients a high quality product at a competitive price
- Program delivery options to complement various population and client needs

We recognize that no two members are alike, so no two plans of care are alike. Our combined programs are created on demand to meet each member's specific needs. Program members benefit from the convenience, privacy and flexibility of self-managed programs that improve their health behaviors, wellness, productivity and performance.

These programs and tools promote health awareness and include educational interventions to more effectively address lifestyle behaviors and leading cost-drivers.

#### **(a) Your criteria for enrollment, including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment;**

APS will utilize various tools to identify members who may be appropriate for engagement in a lifestyle management program. We use the health questionnaire, health screening and medical and pharmacy claims for analysis through our proprietary program. Additionally, APS will telephonically outreach to 100% of the State's members who completes a health questionnaire, a health screening and/or attend a brown bag educational presentation.

Those members who engage in an unhealthy lifestyle such as smoking or whose risk characteristics drive an overall risk score that demonstrates a benefit of a lifestyle management program would be eligible for enrollment in a program. APS' risk stratification takes into

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consideration the above mentioned factors and sources whether self-reported or provided through claims and provides an individual wellness score/risk assessment. We also take into consideration the actual discussion between a Health Coach and member to determine the overall risk. Each of these components contribute toward determining whether the individual should be enrolled in a program.

Enrollment criteria for lifestyle management are based on positively identifying members through their Health Questionnaire, Health Screening and one-on-one assessments.

Program	Criteria
Tobacco Cessation	<ul style="list-style-type: none"><li>Self-report smoking via Health Questionnaire</li><li>Indicates want to work on quitting during one-on-one assessment</li></ul>
Weight Management	<ul style="list-style-type: none"><li>Self-report BMI of 25 or more during one-on-one assessment and/or Health Questionnaire</li><li>Indicates want to work on weight loss during one-on-one assessment</li><li>Elevated weight/BMI and waist circumference via Health Screening</li></ul>
Hypertension	<ul style="list-style-type: none"><li>B/P over 120/80 via Health Screen and/or self-report in Health Questionnaire</li><li>Claims for hypertension (e.g., anti-hypertensive medication/diuretic)</li></ul>
High Cholesterol	<ul style="list-style-type: none"><li>Total cholesterol &gt; 200 or LDL &gt;100 via Health Screen and/or self-report via Health Questionnaire</li><li>Claims for high cholesterol (e.g., anti-hyperlipidemic medication)</li></ul>

### (b) Specific examples of how you integrate evidence-based guidelines and other best practices;

Under our Lifestyle Management Program, the Preventive Care Plan that results from the Health Questionnaire contains recommendations based upon what internal medicine physicians call “*hard prevention*,” complete with actionable next steps so the member can both fully comprehend and directly accomplish the screening. The Health Questionnaire’s medical algorithms are based on a clinical foundation emanating from the real practice of preventive care by the medical advisory team – each of whom are board certified, maintain an active practice, and achieved the top 5% in their certification scores.

Additionally, evidenced based guidelines are rooted throughout APS CareConnection®, providing decision support, educational modules and alerts to focus the intervention with the member. For example, our functional assessments in CareConnection, which are performed by

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Health Coaches/Case Managers, are based upon nationally-recognized clinical guidelines. Based upon these assessments and evidence-based clinical guidelines, CareConnection creates care strategies that become the foundation of the member's POC developed by their clinician and are shared with the member and member's primary care provider and other treating providers if the member approves.

APS utilizes various resources in developing evidence-based programs, content and services that measurably improve the quality, safety, and efficiency of care. All clinical content of our program is developed and approved under the direction of our Clinical Advisory Panel chaired by our Chief Medical Director. Development and review of clinical decision tools involves study of data, professional literature, provider feedback, case trends, input from appropriate, actively practicing practitioners, and recommendations from national specialty associations and organizations.

APS CareConnection – facilitates the integration of “best practices” into our workflows and care processes; our plans of care; reminders and alerts. The knowledge contained in CareConnection provides the basis for assessing, planning, and evaluating the care of members and it reduces variations in care through standardized, evidence-based order sets, POCs, guidelines, pathways, reminders, and alerts. CareConnection also prioritizes each member's needs and sets tasks for the Health Coaches to focus on the highest priorities first.

Evidenced-based guidelines are used to develop our health management and wellness program content and delivery of care. Our guidelines are externally developed, peer-reviewed by providers who have current knowledge relevant to clinical decision support tools, and are research-based. We employ a rigorous research methodology to track the latest research results, best practices, and guidelines. Our in-house physicians, nurses, and pharmacists synthesize the evidence into actionable recommendations designed to help measurably improve the quality, safety, and efficiency of patient care. We ensure the use of nationally recognized guidelines that are consistently applied across all components of our services. Guidelines can also be customized to include local guidelines, evidence, or community best practices.

APS' Program includes various clinical decision support tools (e.g., evidence-based guidelines) that are embedded within CareConnection, as well as our suite of informatics tools (i.e., Johns Hopkins Adjusted Clinical Groups (ACGs) Case-Mix System, Predictive Modeling and our proprietary Treatment Gap Analysis informatics tool).

APS' guideline sources include, but are not limited to:

- Centers for Disease Control (CDC).

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- National Institute of Health (NIH).
  - National Cancer Institute (NCI).
  - National Heart, Lung and Blood Institute (NHLBI).
  - National Institute on Aging (NIA).
  - National Institute of Allergy and Infectious Diseases (NIAID).
  - National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).
  - National Institute of Mental Health (NIMH).
- Global Initiative for Chronic Obstructive Lung Disease (GOLD) Standards.
- American College of Cardiology (ACC).
- American Heart Association (AHA).
- American Diabetes Association (ADA).
- American Psychiatric Association (APA).
- American Academy of Allergy Asthma and Immunology.
- American Academy of Pediatrics.
- American Academy of Family Physicians.
- Institute of Healthcare Improvement (IHI) [Improvement methodologies].
- American Academy of Orthopedic Surgeons (AAOS).
- American Autism Society (ASA).
- March of Dimes.
- U.S. Preventive Services Task Force.

For example, based on the completed assessment within the Lifestyle management program, our case study Fleeta (see **Question C.9** above) was identified with elevated blood pressure and cholesterol. As the Health Coach begins to complete the initial assessments and based on her assessment response, CareConnection will begin to develop a plan of care foundation with recommended goals and interventions for Fleeta based upon evidence-based guidelines.

Some problems, goals, and interventions generated from the hyperlipidemia assessment that are based on the NHLBI National Cholesterol Education Program (NCEP) Third Report of the NCEP Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) (2002) <http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3full.pdf> can be seen below:

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Plan Of Care				
Episode View		Patient View		
Problem			Category	
Knowledge deficit related to frequency of cholesterol checks			Hyperlipidemia	
Target Date	Goal		Goal Type	
12/05/2011	Educate on importance on regular cholesterol checks		ShortTerm	
Intervention		Status	Start Date	Target Date
Review frequency of cholesterol checks in Standards of Care		Open	07/30/2010	12/05/2011
Knowledge deficit related to lipid panel results			Hyperlipidemia	
Target Date	Goal		Goal Type	
12/05/2011	Educate on lipid panel results		ShortTerm	
Intervention		Status	Start Date	Target Date
Review lipid results in Self Management		Open	07/30/2010	12/05/2011
Knowledge deficit related to blood pressure control			Hyperlipidemia	
Target Date	Goal		Goal Type	
12/05/2011	Educate on ATP III guidelines for BP control		ShortTerm	
Intervention		Status	Start Date	Target Date
Review Self Management Interventions		Open	05/31/2010	12/05/2011
Knowledge deficit related to cholesterol management			Hyperlipidemia	

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CareConnection has educational interventions built into the system and are direct interventions based on the assessment generated POC. These educational interventions are aimed at educating the members to begin to develop self-management skills and lifestyle behavior modification. The process of having these interventions at the fingertips of the clinicians has two primary purposes: to provide clinically sound educational information and to create a consistent solitary voice of APS.

The overall design of the educational interventions improve operational efficiencies by decreasing the amount of time clinicians spend researching and maintaining up-to-date evidence based guidelines. It also supports the current need of ongoing support and training initiatives set by APS. Focusing on the Standards of Care set by national health organizations the educational interventions have been grouped into five primary categories:

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1. Standards of Care
2. Self-Management
  - a. Guideline self-management recommendations
  - b. Behavioral Change Interventions
  - c. Stress Management
  - d. Smoking Cessation
3. Medications
4. Nutrition
5. Physical Activity

As part of our assessments, our Coaches evaluate all of the factors behavioral, medical, work life stressors that impact a member's health and ability to break the cycle of unhealthy lifestyle behaviors. Our Coaches pay specific attention to the mind-body connection and thus, actively manage the interplay between the mind and body. This type of approach helps improve the overall health of individuals, reduce total expenditure of health care and ultimately drive improved clinical outcomes. APS' Coaches intimately understand this and look at the member's entire situation and health status to develop interventions that work. APS' Health Coaches have the ability to select appropriate targeted interventions that are built into the CareConnection system and are direct interventions from the POC. Examples of evidence-based guidelines for cholesterol within CareConnection are illustrated below.

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**Cholesterol**

- Standard Of Care**
  - Intervention**
    - CHOL\_ATPIII : The ATPIII (Adult Treatment Panel) Cholesterol Guidelines
- Self-Management**
  - Intervention**
    - CHOL\_Cholesterol : Cholesterol
    - CHOL\_Lipid\_profile : Lipid profile
    - CHOL\_blood\_sugar : Annual fasting blood sugar testing
    - CHOL\_blood\_pressure : ATP III guidelines for blood pressure control
    - CHOL\_Weight\_management : Weight management (BMI)
    - CHOL\_Waist\_measurement : Waist circumference measurement
    - CHOL\_Metabolic\_syndrome : The metabolic syndrome
- Medications**
- Physical Activity**
- Nutrition**

**Complete Education Intervention**

**CHOL\_Metabolic\_Syndrome**

**Health Coach educated member on the metabolic syndrome**

Not all experts agree on the definition of metabolic syndrome. Essentially, metabolic syndrome is a group or cluster of conditions that occur together which increase your risk for heart disease, stroke and diabetes. Different organizations consider some or all of the following as conditions that increase these risks:

- Abdominal obesity
- High Triglycerides
- Elevated Blood Pressure
- Insulin resistance or glucose intolerance
- Elevated C-reactive protein in the blood
- Prothrombotic — high fibrinogen or plasminogen activator inhibitor in the blood)

The American Heart Association and National Heart, Lung, and Blood Institute recommend that metabolic syndrome be identified as having three or more of the following:

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### (c) The frequency and method(s) of interactive contact and other interventions with members;

The frequency of interactive contacts is based upon the member's risk level:

- Lifestyle Management and Low – Members are contacted at least once every two months
- Disease Management and Moderate – Members are typically contacted at least once a month
- Case Management and High – Members are typically contacted at least once a week on average.

With regard to method, APS' wellness/lifestyle management service components of the Health Management & Wellness program will be delivered via a variety of channels – including email, online, telephonically and face to face at the State's worksites throughout the State of Tennessee. The face to face worksite services are critical as our understanding and experience dictates that healthcare delivery is and should be local. APS will employ our local delivery model via community-based Lifestyle Management Health Coaches, Health Coaches, Health Educators, Health Promotion Coordinators, and Provider Liaisons. We will provide not only a worksite presence, but a broader community-based presence.

Utilizing the available data for each member – Health Questionnaire, health screening results, claims data and/or the member's own stated health improvement goals – the Lifestyle Management Health Coach will work with the member to help them define and achieve their wellness goals. The focus throughout is on a holistic, personalized plan for sustainable health improvement. The Lifestyle Management Health Coach will assist the member in addressing multiple health risks, including nutrition, weight, tobacco/smoking cessation, exercise and smoking – maintaining the one-on-one collaborative coaching relationship over time as the member progresses from their primary risks to lower priority risks.

Additionally, during each call with a member, the Health Coach discusses the member's progress with their goals, provides encouragement to keep them focused and motivated to achieving their goals, provides any guidance on working around any identified barriers to their specific lifestyle changes, and provides additional educational resources as necessary to ensure the member continues to achieve their goals. At the end of the call, the Lifestyle Management Health Coach documents where the member is in terms of achieving their goal. This allows us to track and report on an ongoing basis their ability to change their behavior and achieve their stated goal(s) and to evaluate the effectiveness of our health management and wellness program services.

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Our interventions are individualized and customized for each participant's needs and evolve as each member makes progress and/or needs different kinds of assistance. For example, a member who has stopped smoking might experience a significant weight gain and require a different approach meeting this challenge and maintaining and optimizing health.

Because APS' approach is person-centered and also treats co-morbid conditions rather than a single set of health circumstances, APS is able to tailor its services in ways that take into account a member's socio-economic status and life circumstances. For example, a high level manager or director who has more than one disease or chronic condition will need a different kind of intervention than a low-income employee who is not proficient in English with those same conditions. APS' approach is holistic and takes into account these and other life factors, such as what stage of life the member is in, their readiness/ability to change, etc. APS always tailors communication and treatment to the individual participant.

### **(d) The length of each program, including all options;**

The length of time an individual participates in a lifestyle management program is contingent upon the member's risk level and motivation to change. The average duration that a participant is actively engaged with a Lifestyle Management Health Coach and working towards the achievement of an established goal is 90 days.

### **(e) The performance standards for your health coaches;**

#### **Monitoring Performance**

Our staff, tools, and processes ensure that technical assistance, clear milestones of success and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. APS promotes a transparent process of performance measurement, management, and improvement that incorporates our internal findings with feedback from the State, providers, members, and other Tennessee stakeholders.

In this light, APS has a number of quality-driven activities in place to assess the performance or achievement of our clinical team. We are committed to conducting internal quality assurance monitoring to ensure the highest quality health management and wellness services program services are provided to the State's members. Internal monitoring activities include the following:

**Assessment of Performance/Achievements:** APS' performance appraisal system is very goal-oriented. Our Coaches are accountable to the responsibilities noted in their job description and are evaluated on their performance. For example, Performance Appraisal Plan software is used

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to evaluate our Coaches performance and to guide Coaches in maintaining and/or improving future job performance. The Coach Performance Appraisal plan is reviewed semi-annually and annually. As goals are both individual and departmental, linkages are implicit in the Coach's role—they are accountable to the metrics used to represent their performance. As our Disease Management and Case Management programs are currently URAC-accredited, all Coach documentation must meet URAC standards. These standards are very similar in many ways to the NCQA standards for disease management with complex care management, and our clinical documentation audit processes will reflect NCQA standards, to ensure that we will achieve NCQA accreditation within one year of contract go live. Accordingly, one of the annual goals of our Coaches is the degree to which the Coach documents appropriate member assessment, plan of care and member progress in achieving both short and long term goals through planned interventions. The Clinical Operations Manager may also provide formal and informal performance appraisals plans at any other time during a Coach's employment.

**Documentation Audits:** APS provides ongoing review of accuracy and completeness of documentation between Coaches and members/prospective members through documentation audits on active and/or closed cases in APS CareConnection®. Documentation is assessed for timeliness, accuracy and completeness with an aggregate score of 90% or better as the targeted performance standard. The audit includes a review for evidence that the following indicators were documented:

- Eligibility was verified.
- Health management (HM) episode types, such as health and wellness (HW) or disease management (DM), were created using the appropriate referral source.
- Permission for participation in the HM program was obtained.
- Permission for primary care notification and contact was obtained if appropriate.
- Notification of possible call monitoring was discussed.
- Staff member role and benefits of the program were explained to the member.
- Contact attempts by phone and/or letter were completed within established timeframes.
- An initial assessment was completed within established timeframes.
- Short-term and long-term goals were developed with appropriate target dates, in collaboration with the member.
- Follow up contacts/assessments occurred within established timeframes.
- An activity was completed for each contact.
- Provision of resource information and teaching as appropriate.

Sampling of cases are done on a random or targeted basis for each staff member. For example, for our Coaches, five (5) cases per month are screened during their first 90 days. If the employee achieves a 90% or higher aggregate score, the number of cases screened decreases

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to three (3) per quarter thereafter. If at any time the employee scores below an aggregate score of 90%, the number of cases screened reverts back to five (5) per month until the Coach meets the threshold of 90% aggregate score for three (3) consecutive months.

Outcomes of case reviews are shared with individual Coaches and their Supervisor. Documentation audit results are included in the performance evaluation of each Coach. If trends are identified, they are shared among all Coaches through retraining.

**Outcomes Monitoring:** Through the collective work of the Clinical Team (Lifestyle Management Health Coaches, Health Coaches and Case Managers), site by site, contract by contract, clinical outcomes are measured and monitored. Goals are set against external standards and data provided to each site/contract on an ongoing basis. These clinical outcomes are also tied to individual and contract goals, and well aligned with corporate strategic goals. This alignment creates a singular purpose across APS that can be drilled down to the individual practitioner, in the interest of improving healthcare quality in measurable terms.

**Recording of Calls and Silent Monitoring for Content and Customer Service:** Phone services monitoring will be conducted to ensure that efficient, customer-friendly services are provided. APS strives to provide consistent and accurate information to all members. We monitor for the appropriateness of the information that is conveyed to members. The results are used as part of the staff member's annual performance evaluation and to identify quality improvement activities. This audit will be conducted by the QI Manager monthly.

**Complaint Process:** Complaints will be monitored and analyzed on a monthly basis. APS follows a consistent procedure in resolving and responding to complaints. APS tracks and trends the complaints and resolution time to identify areas for improvement. Interventions are developed as necessary and re-measurement is done to ascertain the effectiveness of the intervention. Complaints about APS employees and services are managed and resolved internally by APS staff. Complaints about practitioners or providers will be recorded by APS staff and referred back to the State's health plan vendor.

**Training Evaluations:** All staff training events conducted by APS will include the completion of training evaluation forms. These forms request information from members about content, clarity, and presentation style. Additionally, members are encouraged to provide feedback on future topics and suggestions to make future events better. Evaluation forms are entered into a training database and analyzed at the time of the event and in aggregate quarterly.

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### (f) Ongoing training provided to your health coaches;

APS requires clinical staff to maintain appropriate licensure and provides time and resources to allow staff to do so. Additionally, APS encourages our Lifestyle Management Health Coaches/Health Coaches and Case Managers to complete continuing education classes offered through professional organizations or publications, and to receive professional case management certification. In addition, our Lifestyle Management Health Coaches/Health Coaches and Case Managers maintain memberships in care management and disease-specific organizations and participate in collaborative efforts to develop, review, and revise practice guidelines. Regular review of disease-specific scientific findings ensures that our staff remains current with new emerging technologies and medical advances.

Below is a short listing of some of the topics on which we train our clinical staff. We would welcome discussion from the State on additional training opportunities to be made available to APS staff.

- Disease-specific scientific findings - To ensure that our staff remains current with new emerging technologies and medical advances
- Compliance - APS provides educational opportunities for medical and nursing staff alike to ensure they are compliant with state and medical nursing requirements and also provides financial resources for external educational opportunities
- Customer Service training - The goal of the customer service and outreach training is to provide friendly assistance to all callers. Therefore, our staff is trained in telephone etiquette and technique, problem solving, and empathic listening. This training reinforces our customer friendly approach and ensures that every consumer is treated with respect and dignity.
- Cultural competency training - To ensure staff understand the importance of aligning our chronic care management services to be respectful of the cultural and linguistic nuances of each region and population. From our current programming, we know that culture significantly influences an individual's perception of their health and the healthcare system, as well as how they understand and use the healthcare information and materials they receive.
- Interdependence of physical and mental health care – Provided by trained clinical staff with expertise in behavioral health issues and the unique challenges of treating these members in primary care settings.
- Opportunities for case consultation – Provided by our Medical Director and contracted pharmacist to ensure staff has feedback and information to make sound clinical decisions, referrals, and provide education that will most positively affect a member's health outcomes.

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- Disability Competency Training - APS also recognizes the importance of understanding basic concepts of disability literacy and competence in providing health management and wellness services to persons with disabilities. APS staff will participate in ongoing disability competency training programs. Training modules will focus on key concepts, including understanding the importance of sensitive etiquette practices, personal prejudices, barriers, needs, community resources, and procedures/policies that accommodate persons with disabilities. We will use resources from the local community, including community-based organizations and thought-leaders on disability policy to advise us in developing and conducting the training sessions.

The in-service trainings we offered our clinical staff in 2009 year have included:

- |   |   |
|---|---|
| ▪ Birth defects Education and Awareness | ▪ Osteoarthritis                        |
| ▪ Cervical Cancer                       | ▪ Anxiety                               |
| ▪ Stroke                                | ▪ Asthma                                |
| ▪ Cardiac Procedures                    | ▪ Hypertension                          |
| ▪ Minimal Invasive Procedures           | ▪ Heart Failure                         |
| ▪ Colo-rectal Cancer Prevention         | ▪ Coronary Artery Disease               |
| ▪ Sleep Education and Disorders         | ▪ Physical Activity and a Healthy Heart |
| ▪ Spine-Care and Low-Back Pain          | ▪ Hyperlipidemia                        |
| ▪ Alcohol Use-Education Awareness       | ▪ Chronic Kidney Disease                |

In addition, for staff who choose to participate in outside training opportunities, we are flexible in allowing time off to attend courses. Our policy is to reimburse all costs associated with completion of professional development requirements.

Lastly, our onsite Medical Directors are actively involved in our programs. Our Lifestyle Management Health Coaches/Health Coaches, Case Managers, Provider Liaisons and other clinical personnel will participate in weekly rounds with our Medical Directors, as necessary, to discuss complex cases and opportunities to further integrate providers into the health management and wellness services Program.

### Adult Learning Theory

All trainings that APS conducts - whether for our staff, providers, partners, or members - are based on adult learning theory. We utilize a variety of media (visual, audio, and practice) to assure that adult learners have the utmost opportunity to master the information contained in trainings. Much of our traditional learning experience has led us to believe that we learn best by listening to experts. It has also been found that individuals must actively engage in the individual learning process in order for the learning to create self-awareness, change behavior, and lead to the acquisition of new skills. In particular, adults have been found to learn more

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effectively by doing or experiencing. All of our trainings are designed to convey the message in several ways and to give attendees an opportunity to practice or rehearse the information that they have learned.

### **(g) Your most recent annual turnover rate and average and maximum coach to participant ratio;**

Our most recent annual turnover rate for Lifestyle Management Health Coaches/Health Coaches across our client-specific service centers is less than 10% on average.

Our average case load is 1:400 members. Our maximum coach to participant case load is 1:1200. Caseload is highly dependent on case complexity. Caseload is monitored on a monthly basis and adjusted as necessary. The considerable difference in distribution between regions in Tennessee offers an opportunity to focus health management and wellness services resources according to the disease prevalence of members in each region. If either APS or the State identifies a need to augment our staffing, we will immediately begin recruitment. APS will work with the State to allocate resources appropriately across Tennessee and at the same time ensure that all health management and wellness services program members receive appropriate, person-centered, and effective program services.

### **Staff/Member Ratios**

Staffing for our Coaches and Case managers is team-based. Cases are assigned to staff to assure that those with medically and socially complex care needs have the support they need. With this team-based approach, members can be served by multiple people within that team to best assist that individual. APS monitors the caseload of APS staff – by acuity level – to ensure we are providing adequate resources to meet members' specific needs. We design our workflow to allow each Lifestyle Management Health Coach/Health Coach/Case Manager to have a mix of acuity levels within their caseload, to not only account for the natural tendency of members to move between levels as their needs and health status increase and decrease, but to also provide continuity to members as they are managed by the same Lifestyle Management Health Coach/Health Coach/Case Manager.

We closely monitor caseloads as our health management and wellness services program relies heavily on the use of one-on-one interactions between our clinical staff and enrolled members in order to positively impact member health. Our staff, both field and telephonic, tailor their interventions and outreach to the needs of the members in their caseload, which includes tailoring based on geographic concerns such as barriers to care that exist in rural areas versus those that are urban and how both exist across the State of Tennessee.

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**(h) Samples of your program materials for weight management, tobacco cessation, high cholesterol and hypertension (along with the Flesch-Kincaid reading level of each piece);**

Samples of APS' program materials for weight management, tobacco cessation, high cholesterol and hypertension (along with the Flesch-Kincaid reading level of each piece) are provided in **Exhibit M**. Please note that some items currently have a higher Flesch-Kincaid reading level than required at this time, but APS assures the State that these materials will be modified to a 6<sup>th</sup> grade reading level or less for the State's program. Additionally, our Sample Launch Communication Plan detailing specific materials proposed for the State's program is provided in **Exhibit N**.

**(i) The level of physician involvement and the ongoing use of your medical director(s) and physician consultant(s);**

We know from our past experience implementing health management and wellness program services for other clients that obtaining the acceptance and participation of the broader supporting community is critical to the success of the program. Working with the State, APS will build collaborative community partnerships to garner support from providers. APS has worked hard to successfully establish collaborative partnerships with stakeholders who influence the healthcare community. Just as we do in all of our programs, APS will establish relationships with providers and organizations throughout the State. We understand that collaboration with these key stakeholders is critical to the success of the activities in the State's health management and wellness services program.

In fact, we have already met with numerous provider groups and associations in Tennessee. Over the past several months we have met with the following individuals and organizations:

- Russ Miller, Senior Vice President; Phyllis Franklin, Director of Insurance Affairs, Tennessee Medical Association
- Cathy J. Dyer, Executive Director, Tennessee Academy of Family Physicians
- Catherine M. Fenner, Executive Director, Ruth E. Allen, EPSDT Director, Tennessee Chapter of American Academy of Pediatrics
- Beth Berry, Senior Vice President; Jill Talbert, Assistant Vice President, Advocacy and Grassroots, Tennessee Hospital Association
- Tom Starling, Ed.D., President & CEO, Mental Health Association of Middle Tennessee
- Margaret Smith, Director of Lung Health Programs; Gail Bost, Development Director; Olivia Weiss, Development Manager, American Lung Association of Tennessee

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- Gordon R. Bernard, M.D., Associate Vice Chancellor for Research, Senior Associate Dean for Clinical Services, Joan Randall, MPH, Assistant Professor and Administrative Director, Vanderbilt Institute for Obesity and Metabolism; David Schlundt, Ph.D. Psychology, Institute for Obesity and Metabolism, Vanderbilt University
- Chastity Mitchell, JD, American Heart Association-Tennessee
- John Chiamonte, Jr. Government Relations Director; Carol Minor, Health Systems Director, Tennessee, American Cancer Society
- Shelley Courington, Executive Director, CHART
- Susan Veale, Executive Assistant, Rural Health Association of Tennessee

APS has received a number of letters of support and acknowledgement from these organizations (see **Exhibit H**).

APS discussed this new program with these organizations focusing our discussion on the health management and wellness services area. APS solicited their suggestions on how the program could be implemented most effectively in working with their physicians who serve the state employee, retiree and other covered members. APS also met with a broad spectrum of Tennessee advocacy organizations which strongly support health and wellness for their constituents and advocate for programs such as tobacco cessation. APS pledged its commitment to collaborate with these provider and stakeholder organizations on activities in support of the goals that the Tennessee Department of Finance and Administration wants to accomplish through the Health Management and Wellness Services program. All expressed strong interest in this program and their commitment to work with APS in a collaborative manner if it is selected to administer this program. As an example, APS learned about a special tobacco cessation training program that the Lung Association has developed. We discussed how APS could incorporate it into the Health Management and Wellness Services program.

Working with members and providers from the outset of the program, establishing a Primary Care Medical Home (PCMH) for program members, and working with them to maintain their PCMH, provides a good foundation and continuum of care for health care services, appropriate access to current therapies and treatment regimens, as well as adherence to individual treatment plans. Upon member engagement in the program, APS will work with the member to confirm with that the member has a PCMH he or she is comfortable with. If a member does not have a PCMH, APS staff will work with the member and identify a provider within the State's network. Once the PCMH is established and entered in the APS CareConnection system, our staff will contact each enrolled member's designated PCMH to coordinate management of the care for the member. Members can also identify specialty practitioners involved in their care and access can be granted for these providers to also have access to CareConnection.

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In addition to contacting the designated PCMH upon member enrollment, APS proposes to provide the PCMH with a roster of their individual patients through one of two cost-effective, secure, and efficient methods: (1) web-based access to their patient rosters participating in the program through APS CareConnection; and (2) receiving a password-encrypted email on a monthly basis containing a list of their patients participating in the program. All information concerning members and their medical care will be communicated in accordance with HIPAA regulations. During this provider contact, we will also ascertain if they would like training on CareConnection and if they are interested in clinical education related to care improvement.

In addition, APS will analyze the State's pharmacy claims data to identify members who are non-adherent based upon their MPR and provide feedback to the prescribing provider through our Patient Health Brief (**see Exhibit Q**).

APS has developed and deployed a medication adherence program that takes into consideration the multiple co-morbid conditions and drug interactions for individuals taking multiple medications. Medication management programs have been shown to be effective in reducing costs and improving outcomes by increasing communication between providers, other caregivers and their patients. The process requires changing both member and provider behaviors. The goals of the medication adherence program are to:

- Improve health outcomes related to pharmacy and care practices by closing gaps in treatment and reducing complications or crisis due to lack of medication or treatment adherence;
- Reduce unnecessary costs for payers related to pharmacy and care practices by eliminating avoidable admissions or Ambulatory Sensitive Admissions, utilization as a result of adverse drug events, or waste or divergence from best practices.

APS gives prescribers:

- Claims-based information on therapeutic duplication, omissions in care, usage/non-adherence and behaviors related to uncoordinated care
- Claims and self-reported information on patients' adherence behavior
- Tools to embrace the importance of addressing adherence behavior in patient care
- Principles based on Case Management Adherence Guidelines (CMAG)

As part of our communication with members, we focus on the plan of care to address barriers, including focusing on the member's history of adherence and supporting "*persistence*" (*i.e. discussing medication when it is first started is shown to be an extremely important factor in persistence questions, scores adherence patterns and generates a Plan of Care*). Our program

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also includes educational interventions on common classes of medications and self-management tools.

### **Access to Provider Portal**

One of the greatest benefits of APS CareConnection is that providers and APS staff – Coaches, Case Managers, Health Promotion Coordinators and Provider Liaisons – are all able to see the same information about the member. CareConnection offers an historical view of the member across multiple episodes of care, and includes all of the information related to their health management activities.

Furthermore, the member's provider can view the member's entire clinical history and approve plans of care. As a result, CareConnection acts as a vehicle for communication between our staff and their provider to better coordinate care for the member. We believe that there is no other company that offers providers the ability to view such a complete record of member activity as well as approve the member's plan of care.

### **Medical Director Involvement**

Medical Director, Provider Managers, and Provider Liaisons act as physician extenders in APS' programs. We have constructed a strategic approach to provider integration which employs technology, leverages community-based resources to expand opportunities for education, links providers and members to increase the development of Medical Homes for members, provides an information resource for both providers and members, and links providers and members with our compassionate and skilled Provider and Member Services Teams.

APS' program for the State includes a full-time Medical Director who will be headquartered in the Tennessee-based Service Center. This dedicated position will directly support the Executive Director, Lifestyle Management Health Coaches/Health Coaches and Case Managers and provide clinical input into the operations of APS' program services for the State. The program's Medical Director will concentrate on interacting with the Tennessee medical community and participating providers. This position will primarily be in the field and spend substantial time traveling throughout the state to meet with providers to promote the program and address concerns in person.

The duties of the Medical Director are as follows:

- Provides leadership, oversight and consultation to all departments as is required
- Chairs and convenes the Clinical Advisory Committee
- Participates with any State-designated committees as requested
- Provides professional medical consultation services to APS clinical staff and healthcare community.

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- Ensures that medical and clinical management programs are in compliance with the terms of the State's requirements
- Leverages opportunities for case consultation to ensure staff has feedback and information to make sound clinical decisions, referrals, and provide education that will most positively affect a member's health outcomes

Within our other programs, our Medical Directors are engaged in numerous provider collaboration activities. Specific examples that comprise our health management activities include:

- Communication with previous and/or current treatment providers as well as with the member, family members, and/or support systems
- Review of treatment modalities, interventions and/or programs in which the member has previously participated, specifically targeting potential future interventions to potentially increase treatment outcomes;
- Development of blended and/or innovative modalities, interventions and/or programs for the individual member to potentially increase treatment outcomes
- Evaluation of linguistics, cultural, geographic, economic, and other barriers to care and/or access to care
- Evaluation of current coordination and continuity of care for both behavioral health and medical conditions
- Review of benefit structures and limitations, accessibility and availability of community resources and alternative funding sources for supportive services, which are not normally reimbursable

The Medical Director will provide peer-to-peer discussions with providers on complex cases when needed/requested for consultation on alternative or experimental treatments, applicability of community resources, etc. Criteria for case review may include, but is not limited to, member non-compliance after the APS clinician has exhausted all efforts to manage the member's plan of care or current treatment appears inconsistent with standards of practice or evidence based guidelines or poly-pharmacy, etc.

Further, the APS Medical Director and Provider Relations staff will provide training and education on evidenced-based guidelines, including treating and managing severe mental illness and co-occurring chronic illness. A distinguishing feature of our provider education approach is the extent to which this approach relies upon active provider and community involvement to help shape and adapt the content, format, and venues for APS' provider education program.

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Our approach is to listen and work with the local provider community to help make our provider education more effective and accepted. Through the incorporation of locally published material whenever available, we make available to providers evidence that has already been adopted within their own community – not an approach from “outsiders” with no experience at the local level. APS will work collaboratively with the Tennessee provider associations to offer joint education sessions to their physician members.

### **(j) Follow-up provided when a participant is referred to his/her physician; and**

APS' Lifestyle Management Health Coaches/Health Coaches are responsible for following-up with members who are referred to their physician as part of the care planning process. Follow-up occurs during the next scheduled call between the member and his/her Lifestyle Management Health Coach/Health Coach to make sure the member connected with their physician to address the specific actions items discussed in the member's previous coaching call. Reasons for referral may include obtaining health screening data, discussing their treatment plan and asking questions per the provider checklists for example.

As part of our person-centered approach, our staff also works with members so that they are able to discuss their specific concerns with their providers. For example, if a member is found to be non-compliant with their medications, an alert flag is set in APS CareConnection. For members with an evaluated risk status of high, a Coach or Case Manager will then follow-up on these alerts with the member to identify the extent to which non-adherence is related to medication side-effects. Our rationale for this approach is that high-risk members are placed at even higher risk if they are not adherent with their medications, and that non-adherence may be related to a complex set of circumstances, such as transportation, health beliefs about skipping medications, and side effects of one medication or a combination of medications for individuals with co-morbid conditions. These circumstances could therefore require a variety of problem-solving techniques that our Coaches and Case Managers use to identify and help resolve barriers to adherence to their providers' medication regimens. In addition to proactively working with members to understand the importance of medication adherence, medication side effects and how to manage them, APS also works with members to ensure that they understand the importance of medication storage as well.

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**(k) Copies of published studies or research that provide evidence that each of your lifestyle management interventions are effective.**

Copies of published studies or research that provide evidence of our lifestyle management interventions is provided in **Exhibit O**.

**C.14. Regarding each of your disease management programs under this Contract for the conditions listed in Contract Section A.7.s., describe or provide the following:**

**(a) Your criteria for enrollment, including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment in the program and any risk level(s);**

Our disease management programs focus on delivering increased clinical quality as well as cost management by prioritizing our activities on members at high-risk for high-cost and poor clinical outcomes whose behaviors have the potential to respond to interventions. Examples of enrollment criteria are provided below:

ASTHMA*	
Stratification <sup>2</sup>	Criteria
<b>Mild Intermittent (Low Risk)</b>	Patient experiencing <u>one or more</u> of the following: <ul style="list-style-type: none"><li>▪ Daily symptoms &lt; or = 2 times / week</li><li>▪ Nighttime symptoms &lt; 2 times/month</li><li>▪ Asymptomatic and normal PEF between exacerbations</li><li>▪ Exacerbations brief (from a few hrs. to a few days); intensity may vary.</li><li>▪ PEF variability &lt;20%</li></ul>
<b>Mild Persistent (Low Risk)</b>	Patient experiences <u>one or more</u> of the following: <ul style="list-style-type: none"><li>▪ Daytime symptoms &gt; 2 times/week but &lt; 1 time/day</li><li>▪ Nighttime symptoms &gt; 2 times/month</li><li>▪ Exacerbations may affect activity</li><li>▪ PEF variability 20-30%</li></ul>
<b>Moderate Persistent (Moderate Risk)</b>	Patient experiences <u>one or more</u> of the following: <ul style="list-style-type: none"><li>▪ Daily daytime symptoms</li><li>▪ Nighttime symptoms &gt; 1 time/week</li><li>▪ Exacerbations affect activity</li></ul>

<sup>2</sup> Based on National Institute of Health – National Heart, Lung and Blood Institute (NHLBI), Expert Panel Report, June 2002.

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ASTHMA*	
Stratification <sup>2</sup>	Criteria
	<ul style="list-style-type: none"> <li>Exacerbations &gt; 2 times a week; may last days</li> <li>FEV1 or PEF &gt; 60% - &lt; 80% predicted</li> <li>PEF variability &gt; 30%</li> </ul>
<b>Severe Persistent (Severe Risk)</b>	Patient experiences <u>one or more</u> of the following: <ul style="list-style-type: none"> <li>Continual daytime symptoms</li> <li>Frequent nighttime symptoms</li> <li>Limited physical activity</li> <li>FEV1 or PEF &lt; or = 60% predicted</li> <li>PEF variability &gt; 30%</li> </ul>

AT RISK CARDIAC* (includes hypertension, hyperlipidemia, CAD)	
Stratification	Criteria
<b>Low</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>No symptoms of fatigue, dyspnea, palpitations, and/or angina with physical activity</li> </ul>
<b>Moderate</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>Symptoms of fatigue, dyspnea, palpitations, and/or angina with moderate physical activity and comfortable at rest</li> <li>B/P consistently &gt; 130/85</li> <li>Diagnosed with high cholesterol</li> </ul>
<b>High</b>	Patient experiences <u>at least one</u> of the following: <ul style="list-style-type: none"> <li>Symptoms of fatigue, dyspnea, palpitations, and/or angina at rest or with minimal exertional activity</li> <li>Had an MI in the past 6 months</li> <li>Has uncontrolled arrhythmias</li> </ul>

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COPD*	
Stratification <sup>3</sup>	Criteria
<b>Stage 0 At Risk (Low Risk)</b>	Patient has a chronic cough and sputum production; lung function is normal
<b>Stage I Mild (Low Risk)</b>	Patient experiences mild airflow limitation (FEV1/FVC < 70% but FEV1 > or = 80% predicted) and usually, but not always, chronic cough and sputum production
<b>Stage II Moderate (Moderate Risk)</b>	Patient experiences mild airflow limitation (FEV1/FVC < 50% but FEV1 < 80% predicted), and usually develops symptoms with shortness of breath upon exertion
<b>Stage III Severe (High Risk)</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>▪ Patient experiences further worsening of airflow limitation (30% FEV1 &lt; 50% predicted. OR</li> <li>▪ &gt;2 COPD exacerbations within one year OR.</li> <li>▪ Shortness of breath with even minimal activity.</li> </ul>
<b>Stage IV Very Severe (High Risk)</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>▪ Patient experiences severe airflow limitation (FEV1 &lt; 30% predicted) OR</li> <li>▪ FEV1 50% predicted plus chronic respiratory failure OR</li> <li>▪ History of life threatening COPD exacerbations OR</li> <li>▪ Unable to perform ADLs due to extreme SOB and fatigue.</li> </ul>

<sup>3</sup> Based on the Global Initiative for Chronic Obstructive Lung Disease (GOLD) Standards, July 2003. Panel reviewers included representatives from the National Heart, Lung and Blood (NHLBI) Institute and the World Health Organization (WHO).

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<b>CONGESTIVE HEART FAILURE*</b>	
<b>Stratification</b>	<b>Criteria</b>
<b>Low</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>Class I Low Risk - Patient does not experience symptoms or physical limitations (fatigue, dyspnea on exertion or palpitations).</li> <li>Class II Low Risk - Patient experiences any limitation (symptoms of fatigue, dyspnea or palpitations with physical activity).</li> </ul>
<b>Moderate</b>	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>Class III Moderate Risk - Symptoms of fatigue, dyspnea, palpitations or angina with all physical activities and only comfortable while at rest.</li> </ul>
<b>High</b>	Patient experiences at least ONE of the following: <ul style="list-style-type: none"> <li>Class IV High Risk - Patient experiences symptoms of fatigue, dyspnea, palpitations or angina even when at rest.</li> </ul>

<b>DEPRESSION*</b>	
<b>Stratification</b>	<b>Criteria</b>
<b>Low</b>	Patient does <u>NOT</u> experience any of the High or Moderate criteria.
<b>Moderate</b>	Requires a <u>YES</u> response to one of the following: <ul style="list-style-type: none"> <li>Was the onset of depression before the age of 20, OR</li> <li>Does the patient have a first degree relative who has been diagnosed with depression or who has been treated for depression, OR</li> <li>Is the patient in treatment, i.e., psychotherapy and/or on medication, and showing improvement but still symptomatic, OR</li> <li>Is the patient's medication being managed by primary care physician, OR</li> <li>Has there been a recent change in anti-depressant medications, i.e., increased dosage level, a new anti-depressant, or an augmentation within the past two months, OR</li> <li>Has the patient failed to refill anti-depressant prescription within 10 days of refill due date on &lt; two occasions within the past 12 months, OR</li> <li>Has the patient had no more than one episode of partial hospitalization services or intensive outpatient care during the past 12 months, OR</li> <li>Is the patient scheduled to attend outpatient psychotherapy no more frequently than one visit every two weeks?</li> </ul>

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<b>DEPRESSION*</b>	
<b>Stratification</b>	<b>Criteria</b>
<b>High</b>	<p>Requires a <u>YES</u> response to one of the following:</p> <ul style="list-style-type: none"> <li>Has the patient had two or more episodes of depression within the past two years, OR</li> <li>Has the patient had one or more admissions for inpatient care within the past 12 months, OR</li> <li>Has the patient had two more episodes of PHP services or IOP care during the past 12 months, OR</li> <li>Did the patient have one or more Emergency Room visits for depression-related symptoms with the past 12 months, OR</li> <li>Did the patient fail to refill anti-depressant medication prescription within 10 days of refill due date on three or more occasions during the past 12 months, OR</li> <li>Is the patient scheduled for psychotherapy visits one or more times per week?</li> </ul>

<b>DIABETES*</b>	
<b>Stratification</b>	<b>Criteria<sup>1</sup></b>
<b>Low</b>	<p>Patient does <u>NOT</u> experience any of the High or Moderate criteria <u>AND</u> meets ALL of the following criteria:</p> <ul style="list-style-type: none"> <li>HgbA1c &lt; or = 8.0 in the past year</li> <li>Normal blood pressure</li> <li>Normal lipids</li> <li>Nonsmoker</li> </ul>
<b>Moderate</b>	<p>Patient experiences <u>at least ONE</u> of the following:</p> <ul style="list-style-type: none"> <li>New diabetic diagnosed in the last 1-2 years</li> <li>Inadequate glycemic control with HgbA1c &gt; 8-9</li> <li>Blood sugars &gt; 250, 1-3 times a week</li> <li>Hypertension (SBP&gt;130 mm Hg and/or DBP&gt;80 mm Hg)</li> <li>Dyslipidemia (LDL&gt;100 mg/dL, HDL&lt; 40 mg/dL in males or &lt; 50 mg/dL in females, or TG &gt; 200 mg/dL)</li> <li>Diabetic neuropathy (numbness, tingling in extremities, gait disturbances)</li> <li>Diabetic retinopathy</li> </ul>

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DIABETES*	
Stratification	Criteria <sup>1</sup>
High	<p>Patient experiences at least ONE of the following:</p> <ul style="list-style-type: none"> <li>▪ New diabetic, diagnosed within 1 year</li> <li>▪ Initiation of insulin within past 3 months</li> <li>▪ Admission for diabetes in the past year</li> <li>▪ Admission for cardiovascular related event in the past 6 months</li> <li>▪ Had &gt; 1 ER visit for diabetes in the past year</li> <li>▪ Poor glycemic control, most recent HgbA1c, 9 or greater</li> <li>▪ Blood sugars &gt; 250 more than three times a week</li> <li>▪ Abnormal kidney function (renal insufficiency)</li> <li>▪ Peripheral vascular disease, diabetic foot ulcer, or an amputation</li> </ul>

MUSCULOSKELETAL*	
Stratification	Criteria <sup>1</sup>
Low	<p>Patient experiences at least ONE of the following:</p> <ul style="list-style-type: none"> <li>▪ Experiences no musculoskeletal issues or pain</li> </ul>
Moderate	<p>Patient experiences at least ONE of the following:</p> <ul style="list-style-type: none"> <li>▪ Member has had treatment for condition such as PT, splinting/casting/surgery</li> <li>▪ Member is symptom free for &gt; 7 days</li> <li>▪ Member only needs occasional help with ADL/tasks</li> <li>▪ Member's family relationship has some parts they can't carry out</li> <li>▪ Member uses Nsaids for pain</li> </ul>
High	<p>Patient experiences at least ONE of the following:</p> <ul style="list-style-type: none"> <li>▪ Member has future surgical plans</li> <li>▪ Member has used the ER &gt; 1 time for musculoskeletal within 180 days</li> <li>▪ Member experiences severe to unbearable pain</li> <li>▪ Member experiences &lt;7 symptom free days</li> <li>▪ Member needs help most days to all days for ADL/tasks</li> <li>▪ Members family relationship has many to none parts they can't carry out</li> <li>▪ Member uses narcotic pain relief or muscle relaxants on scheduled basis</li> </ul>

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OBESITY*	
Stratification	Criteria <sup>1</sup>
Low	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>BMI 30 to 34</li> <li>Currently following a diet/exercise plan with weight loss</li> </ul>
Moderate	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>BMI &gt; 34 to 39.9</li> <li>B/P consistently &gt; 130/85</li> <li>Diagnosed with high cholesterol</li> </ul>
High	Patient experiences <u>at least ONE</u> of the following: <ul style="list-style-type: none"> <li>BMI &gt; 40</li> <li>Symptoms of fatigue, dyspnea, palpitations, and/or angina at rest or with minimal exertional activity</li> <li>Fasting blood sugar glucose 91-120</li> </ul>

\* Criteria for each disease include a diagnosis of that condition from the past 6 months or more of claims history.

Our disease management (DM) offerings identify members via claims data, health questionnaires and health screenings, and stratify them for support by level of risk. To stratify members for the various tiers of the Health Management & Wellness program services, APS will use a comprehensive suite of powerful predictive modeling tools – both public domain and propriety. Our approach analyzes demographic data, historical medical, behavioral, and pharmaceutical claims data using statistical algorithms that take into account all major disease diagnoses, since high-risk cases are generally comprised of multiple diagnoses. Through careful analysis of all available data, we will identify individuals, stratify and prioritize outreach not only by burden of disease and predicted cost, but also by the need for improved care coordination and self-management skills to stabilize cost and improve quality of care. Our algorithms also identify members whose behaviors could lead to increased yet unnecessary health care service utilization. Integrating predictive modeling risk scores with clinically-based rules provides an accurate method for targeting coordination efforts and facilitates the allocation of resources to maximize the effectiveness of health management interventions.

In addition, we have adopted advanced data mining techniques to profile individuals with and without chronic diseases to identify instances of *uncoordinated care*. With proprietary algorithms, we use claims and pharmacy data to identify individuals with patterns of care such as avoidable Emergency Room utilization, admissions for ambulatory-sensitive conditions, polypharmacy, duplicate prescriptions from different prescribers, pharmacy-shopping, non-adherence patterns of medication utilization, and frequent PCP changes, for example.

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To conduct the above described predictive modeling services, APS will draw upon the expertise of our team of dedicated and experienced professionals from our Health Intelligence (HI) Division. Our HI staff brings vast experience working with numerous data sources and has produced thousands of analyses and reports on behalf of our customers. These experienced professional analysts provide a unique combination of specialized expertise in areas of clinical and data analysis, and routinely conduct predictive modeling analytics for our customers.

### **(b) Specific examples of how you integrate evidence-based guidelines and other best practices in each disease management program;**

As stated in **Question C.13(b)** above, evidenced based guidelines are embedded throughout APS CareConnection®, providing decision support, educational modules and alerts to focus the intervention with the member. APS CareConnection – facilitates the integration of “best practices” into our workflows and care processes; our plans of care; reminders and alerts. For example, CareConnection’s functional assessments are based upon nationally-recognized clinical guidelines, which then becomes the foundation of the member’s Plan of Care (POC). The knowledge contained in CareConnection provides the basis for assessing, planning, and evaluating the care of members and it reduces variations in care through standardized, evidence-based order sets, POC, guidelines, pathways, reminders, and alerts. APS CareConnection also prioritizes each member’s needs and sets tasks for the Health Coaches to focus on the highest priorities first.

For example, problems, goals, and interventions will be generated from the obesity assessment that are based on the National Heart, Lung, and Blood Institute's (NHLBI) Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults can be seen below:

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Care Plan Preview						
Problem	Problem Status	Goals	Interventions	Status	Met	S
Knowledge deficit related to Metabolic Syndrome	Not Resolved	Educate on Metabolic Syndrome				06
			Review Metabolic Syndrome in Self Management	Open		06
Knowledge deficit related to ideal weight	Not Resolved	Educate on NHLBI Standards of Care				06
			Educate on Obesity Interventions	Open		06
Patient lacks understanding of components of a healthy diet	Not Resolved	Increase understanding of components of a healthy diet				06
			Review Nutrition Interventions	Open		07
			Educate on Pyramid of Food	Open		07
Patient does not know how many calories are right for his/her diet	Not Resolved	Educate on caloric intake based on Pyramid of Food				06
			Review Nutrition Interventions	Open		07
Patient wants to lose weight	Not Resolved	Assist patient in weight loss goal				06
			Review Behavioral Change Interventions	Open		06
			Review Weight Management interventions	Open		06

Complete Education Intervention

**Health Coach educated member on the National Institutes of Health (NHLBI) Standards of Care for Obesity**

NHLBI recommended goals for weight loss and management are to reduce body weight, maintain a lower body weight over the long term and prevent further weight gain.

- Weight Management BMI** 18.5-24.9 kg/m2.
- Waist Circumference**

Men < 40 inches; women < 35 inches.

- Risk Factors:** Metabolic Syndrome
  - Lipid Profile** — as part of the ATPIII guidelines set for cholesterol management
  - LDL < 130
  - HDL > 35
  - FBS** < 100
  - Blood pressure control** =/<140/90 — as part of the JNC7 guidelines for blood pressure management

Diabetes or chronic kidney disease blood pressure should be =/< 130/85

  - Smoking** narrows blood vessels making it hard for the blood to flow properly. NHLBI recommends that all heart patients stop smoking.

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Please see Question C.13(b) above for more details.

### (c) The frequency and method(s) of interactive contact and other interventions with members for each disease management program;

Integrating predictive modeling risk scores with clinical based rules provides an accurate method for targeting coordination efforts and facilitates the allocation of resources to maximize the effectiveness of our interventions. Interventions include member as well as provider focused activities. Additionally, member focused activities include not only clinically focused activities but engagement in psychosocial support activities (i.e. transportation, nutrition, child care) to help members overcome hurdles to seeking and receiving care. These interventions are driven by algorithms within our proprietary technology system APS CareConnection which prioritize work flow for APS staff. Our staff is both telephonic and in the field and our prioritization algorithms are person-centered and highlight the most effective method of intervention (i.e. face-to-face, telephonic, provider focused, etc.) at a specific point in time.

#### Member Interventions

Unlike many programs in which differences in interventions for different risk strata are identified only by frequency, APS interventions are proactive and focus on establishing a patient-centered medical home (PCMH) for members; providing preventive and primary care services that are missing (e.g., mammograms for eligible female members); reducing behavioral health risks (smoking, weight, etc.) that will exacerbate chronic illnesses; identification and remediation of behavioral health and physical health co-morbidities that lead to complications; and education in self-management techniques to maintain and sustain positive lifestyle changes.

APS understands that interventions must be tailored to the individual characteristics of each member, taking into account issues beyond clinical acuity because lifestyle choices impact overall health and poor choices contribute to disease exacerbation. We employ a variety of interventions, all of which are specifically tailored to align with each member's specific motivators for change and address obstacles to achieving desired goals. We help the member develop the courage to make positive changes for themselves through compassionate health coaching. Each member's personalized intervention strategy also includes collaboration with all appropriate healthcare team members to provide comprehensive care. This allows for the maximum success of the treatment plan through acceptance and understanding. While APS Health Coaches will outreach to the State's members on a prioritized basis and based on medical necessity, we are always ready to accept any inbound phone calls from members at all levels to meet their needs. Our Health Coaches are trained in both disease and wellness coaching using motivational interviewing techniques and can focus work with DM members on

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wellness activities (i.e. an asthmatic patient trying to loose weight or reminding a diabetic to make an appointment for a flu shot)

We have structured our program in a way to provide low/moderate risk members with a myriad of resources and tools that will help them achieve their goals, while simultaneously allowing us to focus most of our coaching efforts on individuals with greater complexity and who require a higher degree of attention. All of our member interventions are initiated via our Health Coaches through either face-to-face, phone and/or web-based modalities. In fact, our phone and web-based health coaching programs have been specifically designed to provide members, especially lower risk members, with one-on-one ongoing follow-up and monitoring.

APS' Coaches will work proactively with each member to customize their plan of care (POC) so that it aligns with their specific motivators for change and addresses all relevant factors negatively impacting their health. In each of our interactions with members, our Health Coaches:

- Monitor the member's compliance with recommendations and intervenes when non-compliance is identified
- Assess, plan, implement, and evaluate members' health education needs
- Act as a professional resource for health education
- Provide motivational counseling
- Provide behavioral modification
- Provide education and guidance on the member's condition
- Recommend changes the member can make to improve their health
- Provide medication compliance monitoring
- Enter into collaborative brainstorming and action planning to achieve the member's health goals
- Facilitate proactive planning for sick day and emergency preparedness
- Coordinate local resources that improve compliance with the provider's treatment plan
- Encourage the member to practice habits that support ongoing health, such as helping members make better lifestyle choices concerning weight management, stress management, eating properly, and smoking cessation
- Help members better manage medical, emotional, and personal issues, that may be associated with their condition(s)
- Facilitate improved relationships and communications between the member, their provider(s) and pharmacist

Once HI identifies individuals who are appropriate for the DM program, the individuals are prioritized based on specific triggers so that our Health Coaches can outreach to and try to engage the member in the appropriate health management and wellness services service and

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apply selective interventions. Triggers on the Health Coach's screen in APS CareConnection® alerts them to contact members based on priority of need. This provides Health Coaches with the information they need to know – such as who is in need of outreach immediately – regardless of when the last call was made or the next call is scheduled. The APS algorithms are customized for each client based on clinical, contractual and population rules/triggers.

Additionally, as described above, members who have the potential to become high utilizers of care and cost are also identified through uncoordinated care, predictive modeling technology as well as behavior assessments (i.e., ER use). We believe that this is a unique feature of our approach.

While all members receive basic information and support, including access to APS Health Coaches, members in the “red” or highest need stratification will be prioritized for proactive outreach and will receive the most attention. In APS' model, the intensity and frequency of interventions are mapped to the risk strata, with higher risk members receiving more frequent interventions and lower risk members receiving fewer.

### **Program Interventions for Different Risk Stratification Levels**

Successful program interventions for members at the different risk levels include:

#### **Low Risk:**

- Medical Home identification
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of a recommended plan of care
- Assistance in ensuring compliance with clinical practice guidelines
- General health educational mailing materials
- Preventive Messaging
- 24/7 web-based access to health maintenance and wellness information and goal tracking tools
- Telephonic health and wellness coaching
- Potential for face-to-face contact with a Health Coach or Health Promotion Coordinator
- Ongoing assessment, stratification, monitoring and follow-up
- Generally touched 6-8 times per year but will receive one interactive contact every other month at a minimum

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**Moderate Risk** – For those members considered moderate-risk, APS will administer a more intensive disease management (DM) approach:

- Medical Home identification
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of plan of care (in collaboration with member and provider)
- Assistance in ensuring compliance with clinical practice guidelines
- General health educational mailing materials
- 24/7 web-based access to health maintenance and wellness information and goal tracking tools
- Telephonic health and wellness coaching with a Primary Health Coach
- Potential for face-to-face contact with Health Coach or Health Promotion Coordinator
- Medication and appointment reminders as needed
- Ongoing assessment, stratification, monitoring and follow-up
- Physician outreach/involvement primarily targeting gaps in care and pharmacy management opportunities
- Generally touched 8-12 times per year but will receive one interactive contact every other month at a minimum

**High Risk** – In addition to the services and interventions provided to those members identified as moderate-risk, high-risk members will receive more frequent telephonic contact from their Primary Health Coach, complex case management support, and linkage to available community services:

- Medical Home identification
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of plan of care (in collaboration with member and provider)
- Assist in ensuring compliance with clinical practice guidelines
- General health educational mailing materials
- 24/7 web-based access to health maintenance and wellness information
- More frequent telephonic contact from their Primary Health Coach which includes complex case management support
- Potential for face to face contact with Health Coach or Health Promotion Coordinator
- Linkage to available community services
- Medication and appointment reminders as needed
- Ongoing assessment, stratification, monitoring and follow-up

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### **Physician outreach/involvement**

Generally touched weekly including at Medical Home but will receive one interactive contact every month at a minimum

The above interventions will be accomplished by a combination of Health Coaches and the Health Promotion Coordinator, with the support of a multidisciplinary team consisting of licensed practical nurses, registered dietitians, physical therapists, licensed social workers, certified diabetes educators, nutritionists, smoking cessation experts, exercise physiologists, psychologists, pharmacists and physicians.

A key component to overall population management will be the acquisition of a Medical Home for every member, and collaboration between the Health Coach and the Medical Home to support the provider's treatment plan and ultimately improve the health and overall quality of life for those members with a chronic condition.

### **(d) How you incorporate collaborative practice models that include physician and support-service providers;**

APS works closely with providers in supporting members from day one of enrollment and through ongoing DM interactions with educational materials, state of the art technology, supported assistance and communication to support and empower self management while assuring satisfaction as well as improved health outcomes delivered in a cost effective manner.

### **Collaborative Approach**

APS' approach for the DM program uses the principles of E.H. Wagner and the Chronic Care Model and its focus on three (3) main components:

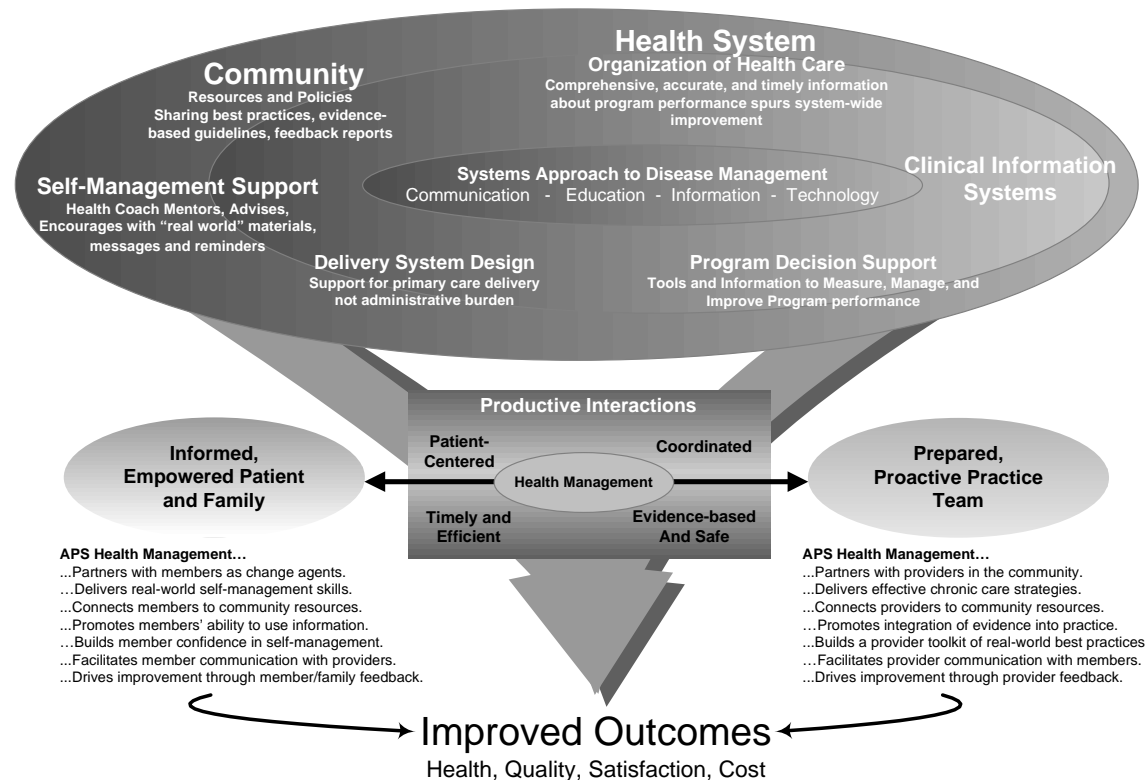
- Member self-management;
- Provider practice/delivery system design; and
- Technological support.

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Our approach is built on our success in other health management programs where we focus on stratification of the population to best prioritize resources. This stratification utilizes multiple sources of information including:

- Claims data which include diagnostic information, Rx adherence behavior and system utilization behaviors
- Assessment results which include information regarding readiness to change, current health perceptions, illness understanding and socio-demographic information

We then employ a person-centered engagement and intervention approach which views the whole-person and considers the physical, behavioral health and social needs of members and collaboration with members' providers/primary care medical homes. Through our HIPAA

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compliant APS CareConnection system we share recommended plans of care with APS staff and the members' providers/primary care medical homes on a real-time basis.

### **Provider Collaboration**

Providers are key to tailoring interventions to meet the needs of each member and an essential component of our program is the ability to promote coordination of care between members and their Patient Centered Medical Home (PCMH). In some cases, members will not have a provider or medical home and need assistance locating and choosing a PCMH. The PCMH model espouses the concept that every member have a primary care provider and that both the provider and the member acknowledge this relationship. By identifying a medical home, we can locate and recommend community supports that extend beyond the member's need for primary care (e.g. mental health, long-term care supports, transportation, etc.). Our goal in engaging the providers and making them a part of our care management team is to encourage them to communicate with all members of the health care team on behalf of the member.

Our Health Coaches build a working relationship with providers and promote the establishment of a medical home by:

- Coordinating care so that an ongoing course of treatment is not interrupted or delayed due to a change in providers.
- Assisting with the transfer of medical record information to new providers in a timely fashion.
- Assisting with the development and implementation of a member/disease registry capable of being shared with other providers.
- Monitoring the referral and follow-up of members in need of specialty care and routine health care services.
- Documentation of referral and follow-up services in members' records.
- Documentation in members' records of emergency medical encounters with the appropriate follow-up as medically indicated.
- Documentation and follow-up in members' records of planned health care services.
- Routinely calling and visiting the PCMH to insure that all information on the member is accurate and complete.

APS staff will guide members in their provider selection process as an initial intervention to empower members toward self-management of their chronic conditions. APS will review both the clinical and access needs for members available through our APS CareConnection system to identify the provider who can best provide the most consistent and reliable medical care. APS' Health Coaches/Case Managers, Health Promotion Coordinators and Provider Liaisons may all work with program members to obtain specific information on access and preferences, including geographic location; transportation resources; language; cultural characteristics; and

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economic issues. In many cases, the provider identified as the medical home will be a family physician or internist, but in cases of severe chronic diseases, the best medical home may be a sub-specialist.

### (e) The average length of each program;

The average duration that a member is actively engaged with a Health Coach and working towards the achievement of their established goals is nine (9) months. Cases remain open as long as there are unmet goals that are attainable and the member agrees to continue with services. Cases are closed according to the following criteria:

- The individual's goals having been met
- The individual is confident and motivated to self-manage
- The individual shows demonstrated ability to sustain their healthy lifestyle behaviors
- The individual no longer has any medical health needs requiring disease management services
- The individual no longer wishes to participate
- The State instructs the Health Coach to close the case
- The individual becomes ineligible (benefits expire)/deceased

APS Health Coaches will provide education, support and guidance until key milestones have been achieved, such as the member has adopted successful self-management skills to properly manage their condition, made the appropriate healthy lifestyle changes, and achieved an optimal level of health. Once a member has reached clinical stability and attained their set goals, based on their unique plan of care, they "graduate" but are placed in a *"maintenance level"* of care.

Members who are at the maintenance level still have the ability to speak with a Health Coach if the need arises and they continue to receive periodic educational mailings. They also undergo ***"watchful monitoring"***; in which each time APS refreshes the claims data it receives from the client, the individual's claims are reviewed and if their condition changes, meaning they are re-identified as being at-risk, they are returned to active status and the appropriate health management initiatives are employed.

APS recognizes that a member with a chronic condition experiences highs and lows. Although the symptoms of a chronic illness may become less intense with proper care, the member still has the underlying condition and as such the susceptibility for their health to change. A chronic condition requires ongoing adjustments by the affected person and interactions with the health care system. As such, APS focuses on empowering and preparing members to manage their health and health care long-term. We:

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- Emphasize the member's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to members

### **(f) The qualifications of your health coaches;**

#### **Dedicated Team with Specialized Knowledge**

APS plans to build staffing for the State's health management and wellness services program that will ensure all wellness/lifestyle management, disease management and case management services are conducted by highly qualified individuals who meet both APS' own rigorous internal standards as well as the State's requirements. All staff will be trained on the State's health management and wellness services program's specific components. We will focus our recruitment efforts on hiring local Tennessee talent. Individuals will be hired based upon their industry experience, their skill sets relevant to their specific positions, their understanding of the State of Tennessee local communities and culture, as well as their shared commitment to the State's mission and objectives. Our goal is to ensure that your members are served by seasoned and knowledgeable staff who truly understands the State, your membership's needs and the State's health management and wellness services program.

Health Coaches are the heart and soul of the APS approach.

#### **The APS Health Coach**

The APS Health Coach is a key member of our DM program team. Our Health Coaches are multi-disciplined health professionals—nurses, nutritionists, dieticians, social workers, or physical therapists who are proactive, customer-focused and have the ability to motivate and inspire program participants to action and sustained behavior change. In addition, our Health Coaches must demonstrate competence with technology and have experience working in a production-driven environment (ability to maximize telephonic contact, call volume and successful engagement results). All Health Coaches are licensed professionals and have 3-5 years of experience.

#### **The Health Promotion Coordinator**

The Health Promotion Coordinator brings their knowledge, experience, and relationships as a community member to benefit your program which brings acceptance among the participant and provider community. The qualifications of the Health Promotion Coordinator are:

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- Bachelor's degree in Nursing, Dietetics or other health related field.
- Professional certification (LPN, CNA, or Social Worker).

Please see **Exhibit J** for job descriptions for the Health Coach and Health Promotion Coordinator.

### (g) The performance standards for your health coaches;

#### Monitoring Performance

Our staff, tools, and processes ensure that technical assistance, clear milestones of success and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. APS promotes a transparent process of performance measurement, management, and improvement that incorporates our internal findings with feedback from the State, providers, members, and other Tennessee stakeholders.

In this light, APS has a number of quality-driven activities in place to assess the performance or achievement of our clinical team. We are committed to conducting internal quality assurance monitoring to ensure the highest quality health management and wellness services program services are provided to the State's members. Internal monitoring activities include the following:

**Assessment of Performance/Achievements:** APS' performance appraisal system is very goal-oriented. Our Coaches are accountable to the responsibilities noted in their job description and are evaluated on their performance. For example, Performance Appraisal Plan software is used to evaluate our Coaches performance and to guide Coaches in maintaining and/or improving future job performance. The Coach Performance Appraisal plan is reviewed semi-annually and annually. As goals are both individual and departmental, linkages are implicit in the Coach's role—they are accountable to the metrics used to represent their performance. As our Disease Management and Case Management programs are currently URAC-accredited, all Coach documentation must meet URAC standards. These standards are very similar in many ways to the NCQA standards for disease management with complex care management, and our clinical documentation audit processes will reflect NCQA standards, to ensure that we will achieve NCQA accreditation within one year of contract go live. Accordingly, one of the annual goals of our Coaches is the degree to which the Coach documents appropriate member assessment, plan of care and member progress in achieving both short and long term goals through planned interventions. The Clinical Operations Manager may also provide formal and informal performance appraisals plans at any other time during a Coach's employment.

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**Documentation Audits:** APS provides ongoing review of accuracy and completeness of documentation between Coaches and members/prospective members through documentation audits on active and/or closed cases in APS CareConnection®. Documentation is assessed for timeliness, accuracy and completeness with an aggregate score of 90% or better as the targeted performance standard.

The audit includes a review for evidence that the following indicators were documented:

- Eligibility was verified.
- Health management (HM) episode types, such as health and wellness (HW) or disease management (DM), were created using the appropriate referral source.
- Permission for participation in the HM program was obtained.
- Permission for primary care notification and contact was obtained if appropriate.
- Notification of possible call monitoring was discussed.
- Staff member role and benefits of the program were explained to the member.
- Contact attempts by phone and/or letter were completed within established timeframes.
- An initial assessment was completed within established timeframes.
- Short-term and long-term goals were developed with appropriate target dates, in collaboration with the member.
- Follow up contacts/assessments occurred within established timeframes.
- An activity was completed for each contact.
- Provision of resource information and teaching as appropriate.

Sampling of cases are done on a random or targeted basis for each staff member. For example, for our Coaches, five (5) cases per month are screened during their first 90 days. If the employee achieves a 90% or higher aggregate score, the number of cases screened decreases to three (3) per quarter thereafter. If at any time the employee scores below an aggregate score of 90%, the number of cases screened reverts back to five (5) per month until the Coach meets the threshold of 90% aggregate score for three (3) consecutive months.

Outcomes of case reviews are shared with individual Coaches and their Supervisor. Documentation audit results are included in the performance evaluation of each Coach. If trends are identified, they are shared among all Coaches through retraining.

**Outcomes Monitoring:** Through the collective work of the Clinical Team (Lifestyle Management Health Coaches, Health Coaches and Case Managers), site by site, contract by contract, clinical outcomes are measured and monitored. Goals are set against external standards and data provided to each site/contract on an ongoing basis. These clinical outcomes are also tied to individual and contract goals, and well aligned with corporate strategic goals.

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This alignment creates a singular purpose across APS that can be drilled down to the individual practitioner, in the interest of improving healthcare quality in measurable terms.

**Recording of Calls and Silent Monitoring for Content and Customer Service:** Phone services monitoring will be conducted to ensure that efficient, customer-friendly services are provided. APS strives to provide consistent and accurate information to all members. We monitor for the appropriateness of the information that is conveyed to members. The results are used as part of the staff member's annual performance evaluation and to identify quality improvement activities. This audit will be conducted by the QI Manager monthly.

**Complaint Process:** Complaints will be monitored and analyzed on a monthly basis. APS follows a consistent procedure in resolving and responding to complaints. APS tracks and trends the complaints and resolution time to identify areas for improvement. Interventions are developed as necessary and re-measurement is done to ascertain the effectiveness of the intervention. Complaints about APS employees and services are managed and resolved internally by APS staff. Complaints about practitioners or providers will be recorded by APS staff and referred back to the State's health plan vendor.

**Training Evaluations:** All staff training events conducted by APS will include the completion of training evaluation forms. These forms request information from members about content, clarity, and presentation style. Additionally, members are encouraged to provide feedback on future topics and suggestions to make future events better. Evaluation forms are entered into a training database and analyzed at the time of the event and in aggregate quarterly.

### (h) Ongoing training provided to your health coaches;

As stated previously, it is our policy to provide our clinicians with the opportunity to enhance their professional knowledge by encouraging attendance at in-service programs and participation in external continuing education programs. APS' training program is designed to provide opportunities for CEU credits and ensure our staff is kept apprised of the latest developments in the medical, disease and behavioral health arenas. We provide various training programs each year, a majority of which allow for the opportunity to earn CEU credits. Please see **Question C.13(f)** for more details on our ongoing training for Health Coaches.

### (i) Your most recent annual turnover rate and average and maximum coach to member ratio;

Our most recent annual turnover rate for Lifestyle Management Health Coaches/Health Coaches across our client-specific service centers is less than 10% on average.

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Our average case load is 1:400 members. Our maximum coach to participant case load is 1:1200. Caseload is highly dependent on case complexity.

Caseload is monitored on a monthly basis and adjusted as necessary. The considerable difference in distribution between regions in Tennessee offers an opportunity to focus health management and wellness services resources according to the disease prevalence of members in each region. If either APS or the State identifies a need to augment our staffing, we will immediately begin recruitment. APS will work with the State to allocate resources appropriately across Tennessee and at the same time ensure that all health management and wellness services program members receive appropriate, person-centered, and effective program services.

### **Staff/Member Ratios**

Staffing for our Coaches and Case managers is team-based. Cases are assigned to staff to assure that those with medically and socially complex care needs have the support they need. With this team-based approach, members can be served by multiple people within that team to best assist that individual. APS monitors the caseload of APS staff – by acuity level – to ensure we are providing adequate resources to meet members' specific needs. We design our workflow to allow each Wellness/Health Coach/Case Manager to have a mix of acuity levels within their caseload, to not only account for the natural tendency of members to move between levels as their needs and health status increase and decrease, but to also provide continuity to members as they are managed by the same Lifestyle Management Health Coach/Health Coach/Case Manager.

We closely monitor caseloads as our health management and wellness services program relies heavily on the use of one-on-one interactions between our clinical staff and enrolled members in order to positively impact member health. Our staff, both field and telephonic, tailor their interventions and outreach to the needs of the members in their caseload, which includes tailoring based on geographic concerns such as barriers to care that exist in rural areas versus those that are urban and how both exist across the State of Tennessee.

### **(j) Samples of your program materials for diabetes, depression, and morbid obesity (along with the Flesch-Kincaid reading level of each piece);**

See **Exhibit P** for sample program materials for diabetes, depression, and morbid obesity (along with the Flesch-Kincaid reading level of each piece). Please note that some items currently have a higher Flesch-Kincaid reading level than required at this time, but APS assures the State that these materials will be modified to a 6<sup>th</sup> grade reading level or less for the State's program.

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## **(k) The level of physician involvement and the ongoing use of your medical director(s) and physician consultant(s);**

The level of physician involvement and use of our Medical Director(s) and physician consultant(s) within our disease management program is identical to our lifestyle management program described in **Question C.13(i)** above.

## **(l) Coordination with providers and EAP/BHO, PBM, and medical TPAs; and**

### **Coordination with Providers**

APS recognizes that involving providers in the program is central to its success for two major reasons:

- Members are more likely to stay enrolled and actively participate in the program if access to their primary care physician (PCP) is maintained; and
- As the program contractor, APS will have more of an impact on evidenced-based treatment practices if the majority of PCPs are actively involved in the program and participate in training, educational activities and quality improvement initiatives.

Our approach to coordinating with the member's treating physician is done in several ways. Providers will have access to our provider portal that is part of APS CareConnection®, Health Coaches may reach out directly and Medical Directors may conduct peer-to-peer discussions for highly complicated cases. Each of these approaches is described below.

- **APS CareConnection Provider Portal** - APS CareConnection acts a secure web-based platform for Health Coaches /Case Managers and our members' providers to communicate about a member's plan of care. For example, through CareConnection's provider portal, providers have the capability, with the member's permission, to view and approve the recommended plan of care for the member. Providers can review the plan of care through a secure Internet connection, and if they agree with it, they simply indicate their agreement. If they wish to modify or expand the plan, they can identify the changes to be made, and an APS Health Coach/Case Manager will update the final plan. Should a provider wish to propose an entirely new plan of care, they may start from a blank sheet. Throughout the process, each implemented plan of care remains available for review, which facilitates outcomes research and provider profiling.

Additionally, the provider and APS Case Manager can share member self-reported information and other pertinent facts in a HIPAA compliant and secure manner. For example, the provider can view the patient's prescription history and fully understand the extent to which prescriptions are filled and utilized. Providers can access the patient's entire

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claims history – what providers they have been to beyond the primary and which medications they are getting filled by the pharmacy – information that otherwise, the provider would not be able to easily access. As a result, CareConnection acts as a vehicle for communication between our staff and their provider to better coordinate care for the member. We believe that there is no other company that offers providers the ability to view such a complete record of member activity as well as approve the member's plan of care.

- **Interaction with Health Coaches** - We fully understand and appreciate that our role is to empower the member and facilitate their relationship with their provider. As such, our approach to honoring the patient/physician relationship has been to provide physicians with actionable clinical information to facilitate early intervention, thereby reducing hospital admissions. If we know who the member's primary provider is and we have been given permission to contact him/her, when urgent/emergent issues are identified, Health Coaches will immediately contact the provider to make them aware of the issue and that their intervention is warranted. For example, when Health Coaches are working one-on-one with an individual member and we identify a potential medication problem or issue – first, we encourage the member to contact their provider and discuss the issue. We will also contact the provider, with the member's permission, to discuss the issue and develop a resolution which we can then communicate to the member and provide continuing support. In addition to contacting the physician via the telephone, we often utilize Clinical Alert Forms to notify a provider when a member's clinical acuity has changed. The Clinical Alert Form (CAF) is sent to physicians whose enrolled patients have exhibited a significant change in medical status, warranting intervention. The CAF is designed to be a medium for facilitating two-way communication between APS' program and the physician.
- **Interaction with APS Medical Director** - Communication with a member's PCP may occur through interactions with an APS Medical Director. A Medical Director may call the treating physician to discuss concerns, provide education and work with the physician to modify the current medication regimen to align with national guidelines. As warranted, we will also get our Medical Directors involved for case conferences and/or peer to peer discussions with providers for highly complex cases.

### Vendor Interface & Coordination

With regard to vendor interface, APS has developed a number of successful interfaces (protocols, data exchanges) with our customers' benefit vendors, and will do the same for the State's external vendors including Magellan for EAP/BHO services, Caremark for PBM services and your various medical TPAs: Cigna, United Healthcare, and BCBS of Tennessee. In fact, we have already established interfaces with Thomson-Reuters, Cigna, United Healthcare, Caremark, Blue Cross Blue Shield of (BCBS) of Alabama, BCBS of Georgia, BCBS of Idaho, BCBS of

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Montana, Accordant, Aetna, ValueOptions, Inc., University of Michigan, Hewitt, Express Scripts, Wells Fargo, ACS, Intracorp, Catalyst Rx, Walgreens and Paramount to name a few – in order to coordinate services. These interfaces include multiple systems and sources and include the data exchange for data such as claims, pharmacy, eligibility, laboratory, incentives and Health Questionnaire data. We are extremely flexible in the development of successful interfaces in order to ensure the most comprehensive and coordinated care possible for the members we serve.

To ensure program success and meet the State's service integration requirement, APS employs proven service integration protocols with our customers' external vendors as well as their internal health initiatives to establish multi-service programs that are seamless to members, resulting in simplified program management for our customers. Specifically for Tennessee, APS will:

- Coordinate with the State's medical TPAs, the PBM, and the EAP/BHO vendor as necessary to ensure that your members receive appropriate services including making appropriate referrals, information sharing, and attending and participating in the required meetings. For example, our clinical staff will participate in weekly conference calls with the medical TPAs, the PBM, and the EAP/BHO vendor to address issues or concerns regarding individual members, particularly members with complex needs. We will also participate in monthly conference calls with the State and representatives from the medical TPAs, the EAP/BHO vendor, and/or the PBM. Additionally, we will participate in quarterly meetings with the State and representatives from the medical TPAs, the EAP/BHO vendor, and the PBM, to improve coordination of their services to members.
- Transmit electronic files to Caremark and your medical TPAs that identifies members who have been enrolled in APS' lifestyle management, disease management, or case management programs while ensuring that only those members enrolled in that TPA are identified to that TPA to preserve member confidentiality.
- Develop "warm transfer" protocols (i.e., referral criteria, referral process) between our staff and your external vendors in cases where the member may need a referral (e.g., to the EAP/BHO benefit).
- Notify your EAP/BHO vendor if a member is enrolled in or receiving DM services for depression and will coordinate services with the EAP/BHO vendor. If a member eligible for DM services for depression also has a current or past diagnosis indicating that the member has serious or persistent mental illness or if the member has had an inpatient admission for a behavioral health condition within the past two (2) years, APS will consult with the State's EAP/BHO case management program to evaluate which program may be more appropriate for the member. If APS and the EAP/BHO agree that the EAP/BHO case management is more appropriate, then APS will refer the member to the EAP/BHO and will not be responsible for providing DM services for depression.

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- Establish member follow-up procedures regarding information that we receive from the medical TPA, including but not limited to information that a member has been admitted to an inpatient hospital, rehabilitative facility, or skilled nursing facility, or has been authorized to receive a transplant or bariatric surgery. For example, if a medical TPA notifies APS that a member has been admitted to an acute care or psychiatric hospital, the member's Health Coach/Case Manager will contact the member. If the member is not enrolled in lifestyle management, disease management or case management, then a Health Coach/Case Manager will contact the member to determine whether he/she should be enrolled in lifestyle management, disease management, or case management.
- Coordinate with the State's medical TPAs in the development of facility discharge plans to ensure appropriate health management and wellness activities are included in the discharge plans. The member's Case Manager will retain a copy of the discharge plan in the member's file.
- Develop and implement a process, which will be prior approved by the State, to receive inpatient discharge planning information from the medical TPAs and EAP/BHO regarding specific members.

Please see **Question C.15(I)** for more details on our coordination activities.

**(m) Copies of published studies or research that provide evidence that each of your disease management program interventions are effective.**

Copies of published studies or research that provide evidence our disease management program interventions are effective are included as **Exhibit O**.

**C.15. Regarding your case management program for this Contract, describe or provide the following:**

**(a) Your criteria for enrollment including data sources, factors used in the risk stratification, weighting of factors, and thresholds/criteria for enrollment in the program and any risk levels;**

Our high-risk complex case management/care coordination approach assesses an entire population via claims and assessment data to identify a subpopulation whose health care service utilization indicates they are at highest risk for poor outcomes and increased cost. APS analyses of multiple population data sets regularly shows that using a sophisticated high cost/high risk stratification approach identifies a group of 20 percent of the members who drive nearly 50 percent of the costs and should respond to improved coordination of care and targeted health education. These members generally have multiple co-morbidities and lack well-coordinated care. Our programs focus on delivering increased clinical quality as well as

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cost management by prioritizing our care management activities on members at high risk for high cost and poor clinical outcomes.

Prospective risk assessment is fundamental to identifying individuals who are or will be experiencing uncoordinated care (i.e., multiple providers, non-emergent ER use, inpatient 30 day readmissions). Integrating predictive modeling risk scores with clinical based rules provides an accurate method for targeting coordination efforts and facilitates the allocation of resources to maximize the effectiveness of care management interventions. Interventions include member as well as provider focused activities. Additionally, member focused activities include not only clinically focused activities but engagement in psychosocial support activities (i.e. transportation, nutrition, child care) to help members overcome hurdles to seeking and receiving care. These interventions are driven by algorithms within our proprietary technology system, APS CareConnection, which prioritize work flow for APS staff. Our staff is both telephonic and in the field and our prioritization algorithms are person centered and highlight the most effective method of intervention at a specific point in time.

APS programs are customized to a client's specific needs and objectives but all of our complex case management programs are built on the following foundational service elements.

- Monthly review of medical and pharmacy claims to Identify members at risk for future high cost utilizations and/or at risk of developing a serious chronic condition(s) using a predictive modeling system
- Daily reports to Health Coaches on Gaps in Care for actions with members and providers
- Utilizing APS CareConnection to share information effectively across healthcare team members to support member and provider decision making and goals while improving the quality of care
- Promoting a Primary Care Medical Home (primary health care provider) as the source of primary healthcare.

A key element of APS' programs is our proprietary technology - APS CareConnection. CareConnection is the essential system we use to incorporate demographics, patterns of care, and Health Questionnaires for care coordination and intense case management. It provides an integrated diagnostic and service database; a plan of care for enrollees; and provides alerts between primary care providers and APS staff to initiate interventions.

For our complex case management programs, the unique capabilities of APS CareConnection serve as the infrastructure of the healthcare neighborhood, supporting the primary care medical home with a comprehensive, integrated, person-centered database. One of the most significant benefits to CareConnection is that it represents a single source of information that houses all relevant care management tools – data, guidelines and

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criteria, individual treatment plans, health status assessments, communications, and interventions – in a single site that is accessible to all providers, via a HIPAA compliant provider portal, and APS clinical staff. This integrated resource promotes the type of productive interactions that are essential for the success of a complex case management program and supports provider teamwork.

## Identify & Stratify Members

- APS' programs begin with a proprietary stratification process
  - Stratification tools validated by population – APS uses Johns Hopkins Adjusted Case Mix System
  - Enhanced with APS algorithms to identify the highest cost/highest risk clients with *impactable conditions*
  - APS analyses of multiple data sets identify highest priority clients:
    - Have multiple disorders
    - Use multiple providers
    - Have utilization patterns that drive uncoordinated and often unnecessary care
- Prioritizing high cost/risk patients and high volume providers to drive daily work flow
  - Percolator<sup>SM</sup>: Prioritize clients with greatest needs and opportunity for improvement

## Identification and Prioritization of Outreach

APS uses a variety of approaches to proactively identify and outreach to members who have the potential of becoming high-cost health care consumers including:

- **The utilization review process.** Nurse Reviewers are ideally positioned to identify members for complex case management at the point of service request based on a diagnosis/procedure trigger list; extended-stay cases; conditions not responding to medical care; cases at risk for exacerbation of illness; complicated discharge planning; high-cost diagnosis; high-cost claims; multiple hospitalizations or emergency room visits for the same diagnosis; or use of multiple providers of care. APS will establish data exchange and referral protocols with the State ensuring that APS will have immediate access to authorization information for case-finding purposes.
- **Referrals.** Referrals from the member, their physicians, and other vendors.
- **Using informatics-based tools.** Utilizing our proprietary analytic process and uncoordinated care analysis, enables us to prioritize outreach efforts to target real-time case management of high risk members with whom we can make the greatest impact – both clinically and financially.

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APS' approach targets members with the highest risk, highest cost, and with impactable conditions for enrollment in case management. Enrollment into case management is dependent on specific algorithms established by APS. The algorithm would include include factors such as:

- Proprietary Stratification process (e.g., the top 5 - 10% of the highest risk, highest cost members would be included).
- Analysis of impactable conditions using triggers to identify high cost conditions, high cost procedures that can be successfully managed.
- Analysis of which high cost behaviors are impactable (i.e., repeated ER use for non-emergent or ambulatory care sensitive conditions).

### **(b) Specific examples of how you integrate evidence-based guidelines and other best practices;**

As stated in **Question C.13(b)** above, evidenced based guidelines are embedded throughout APS CareConnection, providing decision support, educational modules and alerts to focus the intervention with the member. APS CareConnection – facilitates the integration of “best practices” into our workflows and care processes; our plans of care; reminders and alerts. For example, APS CareConnection’s functional assessments are based upon nationally-recognized clinical guidelines, which then become the foundation of the member’s plan of care (POC). The knowledge contained in APS CareConnection® provides the basis for assessing, planning, and evaluating the care of members and it reduces variations in care through standardized, evidence-based order sets, POCs, guidelines, pathways, reminders, and alerts. APS CareConnection also prioritizes each member’s needs and sets tasks for the Health Coaches to focus on the highest priorities first.

For example, Ezekial, a 59-year-old male retiree in Union City, Tennessee explains that he has been depressed for at least two months in duration and has a body mass index (37) that indicates that he is morbidly obese. The Case Manager will complete the initial assessments and based on his assessment responses, CareConnection will begin to develop a system generated plan of care with recommended problems, goals, and interventions for Ezekiel.

Goals, and interventions will be generated from the depression assessment, and are based on the following guidelines for depression:

- American Psychiatric Association Practice Guidelines for the Treatment of Patients with Major Depressive Disorder (2000, 2005);
- University of Michigan Health System: Depression (2005 Update)
- Institute for Clinical Systems Improvement Practice Guidelines for Depression (2006)

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- APA's Guidelines Watch: Practice Guideline for the Treatment of Patients with Major Depression Disorder, 2nd Edition (2000)
- Institute for Clinical Systems Improvement Major Depression in Adults in Primary Care May 2009

Interventions based upon evidence-based guidelines are illustrated below.

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Plan Of Care

Episode View

Patient View

Problem		
Patient is not seeing a psychotherapist		
Target Date	Goal	
10/24/2011	Patient will be evaluated for appropriateness of psychotherapy	
Intervention		Status
Educate patient on Standards of care re: psychotherapy as part of treatment of depression		Open

Problem		
Patient not taking antidepressant		
Target Date	Goal	
10/24/2011	Patient takes antidepressant medication	
Intervention		Status
Educate member on importance of medication adherence		Open

Intervention/Start Date:

05/31/2010

12:00 AM

12:00 AM

Target Date:

10/24/2011

Assign Nurse:

Groenier Christine

Frequency:

Monthly

Intervention:

(For a quick search please enter 3 chars from Intervention)

Educate patient on Standards of care re: psychotherapy as part of tre.

Educate patient on Standards of care re: psychotherapy as part of treatment of depression

Other:

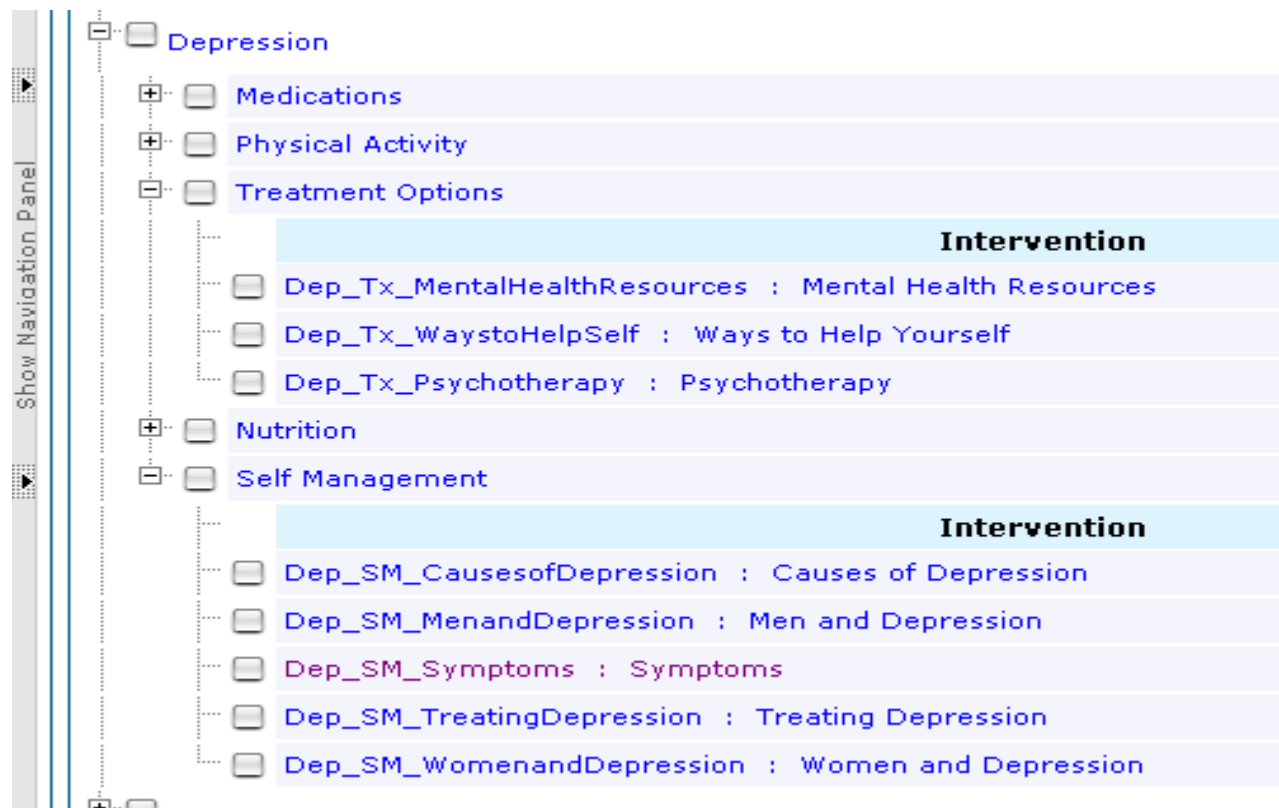
Cancel

Save

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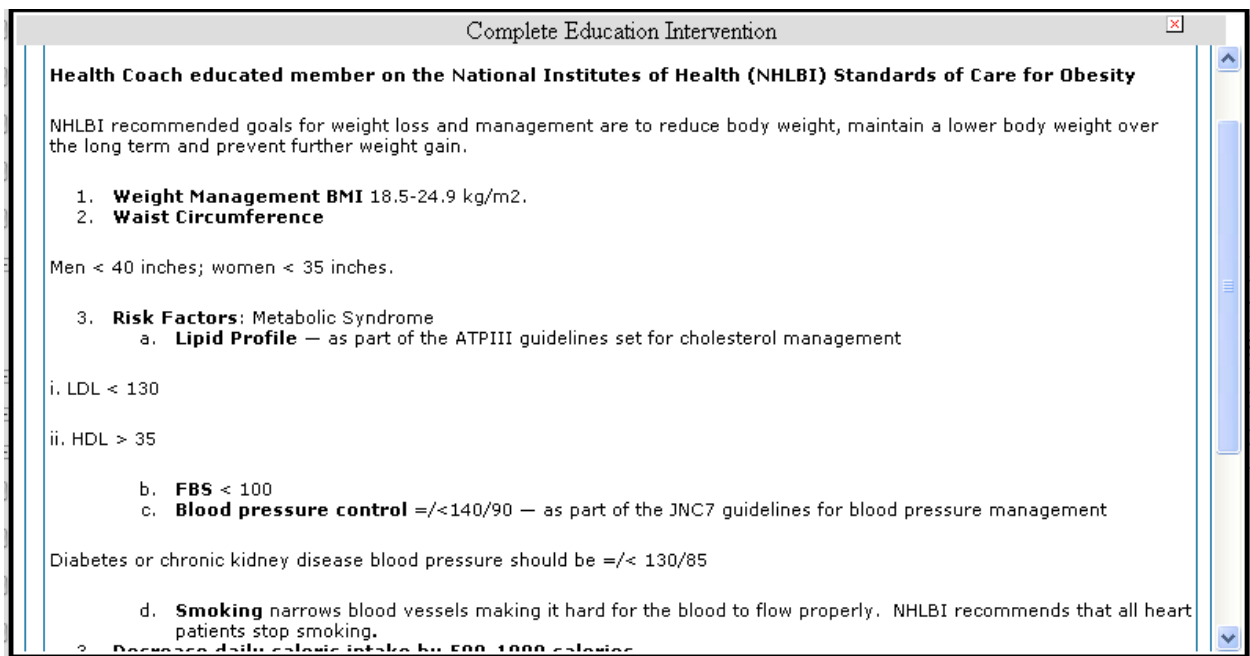
A copy of the plan of care with APS CareConnection that can be mailed to Ezekial to track his progress are also illustrated below:

Care Plan Preview						
Problem	Problem Status	Goals	Interventions	Status	Met	S
Knowledge deficit related to Metabolic Syndrome	Not Resolved	Educate on Metabolic Syndrome				05
			Review Metabolic Syndrome in Self Management	Open		05
Knowledge deficit related to ideal weight	Not Resolved	Educate on NHLBI Standards of Care				05
			Educate on Obesity Interventions	Open		05
Patient lacks understanding of components of a healthy diet	Not Resolved	Increase understanding of components of a healthy diet				05
			Review Nutrition Interventions	Open		07
			Educate on Pyramid of Food	Open		07
Patient does not know how many calories are right for his/her diet	Not Resolved	Educate on caloric intake based on Pyramid of Food				05
			Review Nutrition Interventions	Open		07
Patient wants to lose weight	Not Resolved	Assist patient in weight loss goal				05
			Review Behavioral Change Interventions	Open		05
			Review Weight Management interventions	Open		05

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Please see Question **C.13(b)** for more details.

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## (c) The frequency and method(s) of interactive contact and other interventions with members;

APS believes that by utilizing all resources available to program members, we can provide the most comprehensive and effective management, while addressing individual needs. Interventions are adjusted and targeted according to the client's program objectives and the member's real-time need as detailed below by stratification level. For the State, the high cost/high risk group will be stratified into three (3) distinct levels of need. Our efforts will focus on those individuals that we can positively impact. For example, even among the highest risk/highest cost members, some individuals utilize health care services appropriately and thus require less frequent interaction with a Health Coach. The table below shows examples of patients in this high risk/high cost group. The State's resources are best deployed against the members in this group for whom interventions can make the most impact from a quality and cost perspective. Those in the lowest group still need access to support and monitoring to ensure they don't escalate to higher tiers.

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	Member A	Member B	Member C	Member D
2 Yrs Data	PMPM Top 5% Cost \$3,950 Intense DM Intervention	PMPM Top 20% Cost \$2,100 Moderate DM Intervention	PMPM Top 5% Cost \$3,990 Aggressive Wellness Intervention	PMPM Remaining 75% \$119 Aggressive Wellness Intervention
Diagnoses	<ul style="list-style-type: none"> <li>Diabetes</li> <li>Asthma</li> <li>Depression</li> </ul>	<ul style="list-style-type: none"> <li>Diabetes</li> <li>Depression</li> </ul>	<ul style="list-style-type: none"> <li>Diabetes</li> <li>ESRD</li> </ul>	<ul style="list-style-type: none"> <li>None</li> </ul>
PCP Visits/Year	1 – Gaps in testing (HbA1c, etc.)	3 – No eye exam	4 – Full compliance with testing (HbA1c, etc.)	1 - well person visit
ER Visits/Year	5	2	0	0
MPR	Diabetes .25; Asthma .10; Depression .50	Diabetes .80 Depression .80	Diabetes .80	0
Keeps Medical Appointments	<50% of the time	<50% of the time	90% of the time	NA
Inpatient Admissions	5: Some with readmission within 30 days	3: Preventable admissions	1: Dialysis related	0

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**High** - In addition to the services and interventions provided to those members identified as moderate-risk below, high-risk members will receive more frequent telephonic contact from their Primary Case Manager, complex case management support, and linkage to available community services:

- Prioritized Outreach efforts to engage members in the program
- Engage member: Face to face; telephonic; mail
- Engage provider on behalf of member / Medical Home identification
- Engage social services on behalf of member and linkage to available community services
- Medication Adherence Program
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of plan of care (in collaboration with member and provider)
- Assistance in ensuring compliance with clinical practice guidelines
- 24/7 web-based access to health maintenance and wellness information
- More frequent telephonic contact from their Primary Case Manager which includes complex case management support
- Ongoing assessment, stratification, monitoring and follow-up
- 24/7 access to nurse line

**Moderate:**

- Outreach efforts to engage members prioritized based on risk to escalate to high risk level. Members can also self refer or be referred by providers
- Medical home identification
- Assessment of immediate needs/knowledge
- Regular monitoring
- Medication Adherence Program
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Physician outreach/involvement
- Development of plan of care (in collaboration with member and provider)
- Assistance in ensuring compliance with clinical practice guidelines
- 24/7 web-based access to health maintenance and wellness information
- Telephonic engagement and education with a Primary Case Manager
- Medication and appointment reminders as needed
- Ongoing assessment, stratification, monitoring and follow-up
- 24/7 access to nurse call line

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## ***Low/Base Services:***

- Engagement is through self or provider referral
- Medical home identification
- Identification of barriers to care
- Identification of strategies/ resources to overcome barriers to care
- Development of plan of care (in collaboration with member and provider)
- Assistance in ensuring compliance with clinical practice guidelines
- 24/7 web-based access to health maintenance and wellness information
- Telephonic engagement and education with a Primary Case Manager
- Encourage greater self-monitoring skills
- Increase health literacy
- 24/7 access to nurse call line

Our approach is to address issues concurrently. Therefore, our focus is not only on ensuring the appropriate clinical treatment is provided, but at the same time we address financial and psychosocial issues which can impact the effectiveness of the plan of care (POC).

APS will utilize both its Tennessee-based telephonic Case Managers and field-based staff to make contact and interact with members identified as appropriate for case management. Once individuals are identified as appropriate for case management, their contact or level of interaction is prioritized and will vary according to their risk level.

## **Frequency of Member Contacts**

Every case identified is evaluated based on the severity of the illness/injury or disease, complexity of the case, and the role requirement of case management. The evaluation determines the risk level. The risk stratification is based on the member's total illness burden, ensuring that all factors impacting the member's health are addressed.

Contact by the Case Manager will vary according to the risk level for each member. APS has three risk levels in addition to a "benefit management level":

- High or Very-High
  - Contact with member and/or provider, at a minimum, on a weekly basis
- Moderate
  - Contact with member and/or provider, at a minimum, every two weeks
- Low
  - Contact with member and/or provider on, at a minimum, every month.

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**(d) The average length of case management;**

**Average Time Case Open**

The average time a case remains open is 90 - 120 days. We may have Case Management cases that are only open for about six (6) weeks. These types of cases are for members that are usually healthy but may require short term care coordination.

**Closing Cases**

Engaged members are discharged from the program and back to the exclusive care of the primary care physician/primary medical home according to the following criteria:

- The member no longer has any medical health needs requiring complex case management
- The member no longer wishes to participate
- the State instructs the Case Manager to close the case
- The member becomes ineligible (benefits expire/deceased)

Once a member is discharged back to the medical home, APS continually conducts claims analyses – *watchful monitoring* – using our proprietary informatics tools to identify individuals who would benefit from our complex case management services. Additionally, a member can be re-identified for complex case management during the utilization review process if he/she meets any of the complex case management triggers. Lastly, members can be referred for case management services by the member themselves, their physicians, external vendors, etc.

**Case Management Goals Met**

APS believes that members who have made demonstrable progress toward goal completion, but who remain at high-risk status (as evidenced by solid criteria such as predictive modeling, multiple co-morbidities, utilization of services, and/or significant social support concerns) should continue to stay engaged in case management services.

Sustained, meaningful outcomes can often be accomplished by setting a smaller number of realistic goals over a longer period of time (e.g. one year), rather than attempting to accomplish all goals over a pre-set finite period of time. Additionally, the development of new diagnoses and exacerbations of co-morbid conditions will necessitate re-engagement of members beyond any initial intervention period for the assessment of these new and/or exacerbated conditions.

Because APS places great importance on the Medical Home and the provision of optimal primary care, we would communicate with the member's primary care provider in developing medically appropriate, attainable, measurable and time-oriented goals. This will allow us to

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more accurately determine if significant healthcare utilization or non-compliant behaviors have occurred, which might not yet be evident in the State's claims data.

### **(e) The qualifications of your case managers;**

#### **Tennessee-Based Case Management Staff**

The APS approach to program management employs a local and collaborative community-based model with a team based staffing approach. We deploy this model because it provides the kind of dedicated attention to members and providers that is needed in order to facilitate overall improved health outcomes and cost savings and deliver value to our clients.

Our teams include staff providing direct care management services to consumers as well as additional staff to support members' information and resource needs. Those providing direct care management are our Case Managers.

#### **Tennessee-Based Case Managers**

We require our Case Managers (100%) to be licensed, experienced health care professionals with three (3) - five (5) years of direct clinical experience in a hospital or outpatient setting prior to being hired by APS. 90% of our Case Managers have five (5) years of experience at the time of hire on average.

Our Case Managers include licensed registered nurses and certified Case Managers who are responsible for providing clinical management and coordination of high-risk medical cases. In addition, APS employs specialty clinicians to support the case management process, including registered dietitians, registered therapists, certified diabetes educators and pharmacists.

The State team will also include Provider Liaisons to support continuity between members and their providers via engagement directly with provider offices. Provider Liaisons at a minimum must have a Bachelor's degree in healthcare or business-related field; must demonstrate a solid understanding of health management or have a combination of related education/experience; have a minimum of five (5) years of customer service experience in healthcare services and/or provider relations; and experience working with physicians, healthcare professionals, and social service systems of care.

### **(f) The performance standards for your case managers;**

#### **Monitoring Performance**

Our staff, tools, and processes ensure that technical assistance, clear milestones of success and appropriate interventions are in place, consistently measured, and available for assessment of overall quality performance. APS promotes a transparent process of performance

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measurement, management, and improvement that incorporates our internal findings with feedback from the State, providers, members, and other Tennessee stakeholders.

In this light, APS has a number of quality-driven activities in place to assess the performance or achievement of our clinical team. APS is committed to conducting internal quality assurance monitoring to ensure the highest quality health management and wellness services program services are provided to the State's members. Internal monitoring activities include the following:

**Documentation Audits:** APS provides ongoing review of accuracy and completeness of documentation between Lifestyle Management Health Coaches/Health Coaches/Case Managers and members/prospective members through documentation audits on active and/or closed cases in APS CareConnection. Documentation is assessed for timeliness, accuracy and completeness with an aggregate score of 90% or better as the targeted performance standard.

Sampling of cases are done on a random or targeted basis for each staff member. For example, for our Case Managers, five (5) cases per month are screened during their first 90 days. If the employee achieves a 90% or higher aggregate score, the number of cases screened decreases to three (3) per quarter thereafter. If at any time the employee scores below an aggregate score of 90%, the number of cases screened reverts back to five (5) per month until the Case Manager meets the threshold of 90% aggregate score for three (3) consecutive months.

Outcomes of case reviews are shared with individual Case Managers and their Supervisor. Documentation audit results are included in the performance evaluation of each Case Manager. If trends are identified, they are shared among all Case Managers through retraining.

**Assessment of Performance/Achievements:** APS' performance appraisal system is very goal-oriented—our Case Managers are accountable to the responsibilities noted in their job description and are evaluated on their performance. For example, Performance Appraisal Plan software is used to evaluate our Case Managers' performance and to guide Case Managers in maintaining and/or improving future job performance. The Case Manager Performance Appraisal plan is reviewed semi-annually and annually. As goals are both individual and departmental, linkages are implicit in the Case Managers' role—they are accountable to the metrics used to represent their performance. As our Disease Management and Case Management programs are currently URAC-accredited, all Coach documentation must meet URAC standards. These standards are very similar in many ways to the NCQA standards for disease management with complex care management, and our clinical documentation audit processes will reflect NCQA standards, to ensure that we will achieve NCQA accreditation within one year of contract go live. Accordingly, one of the annual goals of our Case Managers is the degree to which the Case Manager documents appropriate patient assessment, plan of

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care and patient progress in achieving both short and long term goals through planned interventions. The Clinical Operations Manager may also provide formal and informal performance appraisals plans at any other time during a Case Manager's employment.

**Outcomes Monitoring:** Through the collective work of the Clinical Team (Lifestyle Management Health Coaches, Health Coaches and Case Managers), site by site, contract by contract, clinical outcomes are measured and monitored. Goals are set against external standards and data provided to each site/contract on an ongoing basis. These clinical outcomes are also tied to individual and contract goals, and well aligned with corporate strategic goals. This alignment creates a singular purpose across APS that can be drilled down to the individual practitioner, in the interest of improving healthcare quality in measurable terms.

**Silent Monitoring & Call Recording for Content and Customer Service:** Phone Services Monitoring will be conducted to ensure that efficient, customer-friendly services are provided. APS strives to provide consistent and accurate information to all members. We monitor for the appropriateness of the information that is conveyed to members. The results are used as part of the staff member's annual performance evaluation and to identify quality improvement activities. This audit will be conducted by the QI Manager monthly.

**Complaint Process:** Complaints will be monitored and analyzed on a monthly basis. APS follows a consistent procedure in resolving and responding to complaints. APS tracks and trends the complaints and resolution time to identify areas for improvement. Interventions are developed as necessary and re-measurement is done to ascertain the effectiveness of the intervention. Complaints about APS employees and services are managed and resolved internally by APS staff. Complaints about practitioners or providers will be recorded by APS staff and referred back to the State's health plan vendor.

**Training Evaluations:** All staff training events conducted by APS will include the completion of training evaluation forms. These forms request information from members about content, clarity, and presentation style. Additionally, members are encouraged to provide feedback on future topics and suggestions to make future events better. Evaluation forms are entered into a training database and analyzed at the time of the event and in aggregate quarterly.

### **(g) Ongoing training provided to your case managers;**

As stated previously, it is our policy to provide our clinicians with the opportunity to enhance their professional knowledge by encouraging attendance at in-service programs and participation in external continuing education programs. APS' training program is designed to provide opportunities for CEU credits and ensure our staff is kept apprised of the latest developments in the medical, disease and behavioral health arenas. We provide various

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training programs each year, a majority of which allow for the opportunity to earn CEU credits. Please see **Question C.13(f)** for more details on our ongoing training for Case Managers.

### **(h) Your most recent annual turnover rate and average and maximum case manager to member ratio;**

Our most recent annual turnover rate for Case Managers across our client-specific service centers is less than 10% on average. Specifically for Tennessee, APS has established a caseload ratio of approximately 1:300 cases per Case Manager. As previously stated, caseload is highly dependent on case complexity.

### **(i) Your plan and script for outbound contact with a potentially pregnant member in order to screen the member's risks;**

In accordance with the State's requirements, if we determine that a member is pregnant (e.g., based on information provided by the State or its vendors), APS will reach out to the member within five (5) business days of notification. APS will then conduct a brief screening to determine whether the member is at high risk (according to the definition of "high risk pregnancy" in The Merck Manual for Healthcare Professionals and as prior approved by the State). APS' Case Managers gather member information using our advanced technology platform, APS CareConnection. The assessment tool explores the expectant mother's demographic data, risk factors, behavioral and medical co-morbidities, lifestyle, psychosocial well-being, and willingness to learn self-management skills. During the assessment, our Case Managers capture the following risk factors within our system:

- Personal and family medical history (i.e., birth defects, blood disorders, hypertension, etc. as well as their relationship to the mother).
- Risk factors (i.e., drug abuse/current, < 18/>35 years old, cesarean section planned this pregnancy/history, diabetes, pre-term labor/birth history, hypertension, obesity, nutritional compromise, multiple gestation, smoker, thyroid dysfunction, recurrent miscarriages (>2), etc.).
- Environmental lifestyle:
  - Exposure to harmful agents (i.e., alcohol, cats, work hazards, etc.)
  - Occupation (i.e., homemaker, light/heavy assembly, stand >4 hours, number of hours, etc.)
  - Household (i.e., lives alone, with father, with siblings, etc.)
  - Initial Smoking Status (i.e., <10/day, 10-20/per day, 20-40/ day, >40/day etc.)
  - Present Smoking Status (i.e., quit 1st / 2nd /3rdtrimester, <10/day, 10-20/per day, 20-40/ day, >40/day)

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While we ensure our operations are aligned with nationally recommended practice guidelines, we also utilize the clinical expertise of our Case Managers to capture all elements of the member's life that will impact her ability to attain or maintain healthy pregnancy behaviors and then employ the most effective interventions that achieve this end.

If the member is at high risk, APS will inform her of the services available under the Health Management & Wellness Program, and offer to enroll her in the appropriate case management program. If the member is not high risk but has some risk factors (i.e., smoking) that may complicate her pregnancy we will inform her of the availability of lifestyle or disease management programs. We will also use this opportunity to encourage her to complete a health questionnaire, offer assistance with accessing the health questionnaire or other resources, and discuss potential next steps.

The initial call to the member is designed to introduce the program and to "set the stage" for ongoing engagement with the member. A sample script of this outreach call is provided below (please note scripts will be approved by the State):

*"Hello, my name is Jane Doe. I am a Nurse with your ParTNers For Health Program. I am calling you today to introduce a free educational program on maternity. The program is based on National Guidelines set by the American Congress of Obstetricians and Gynecologists (ACOG). Essentially, I will call you at least once a month to check in with you, see how things are going for you and answer any questions you may have about taking care of your pregnancy. We know that your time is valuable and we work to make each phone call 10-15 minutes in length. We strive to make your time with us as beneficial as possible so we want to make sure and spend the time on areas that are of the most interest to you. In order for us to get started I would like to ask you a few questions about where you are in your pregnancy. "*

### **(j) Samples of your program materials for high risk pregnancy (along with the Flesch-Kincaid reading level of each piece);**

Sample program materials for high risk pregnancy are provided in **Exhibit V**.

### **(k) The level of physician involvement and the ongoing use of your medical director(s) and physician consultant(s);**

As stated above, APS understands that from our past experience implementing health management programs for other programs that obtaining the acceptance and participation of the broader supporting community is critical to the success of the program. Working with the

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State, APS will build collaborative community partnerships to garner support from providers. APS has worked hard to successfully establish collaborative partnerships with stakeholders who influence the healthcare community. APS will establish relationships with providers and organizations throughout the State as we've done in other programs. We recognizes that collaboration with these key stakeholders is critical to the success of the activities in the State's complex case management program.

We work with members and providers from the outset of the program. This includes establishing a Primary Care Medical Home (PCMH) for members and working with them to maintain their Medical Home – all of which provides As part of our person-centered approach, our staff also works with members so that they are able to discuss their specific concerns with their providers. For example, if a member is found to be non-compliant with their medications, an alert flag is set in APS CareConnection. For members with an evaluated risk status of high, a Coach or Case Manager will then follow-up on these alerts with the member to identify the extent to which non-adherence is related to medication side-effects. Our rationale for this approach is that high-risk members are placed at even higher risk if they are not adherent with their medications, and that non-adherence may be related to a complex set of circumstances, such as transportation, health beliefs about skipping medications, and side effects of one medication or a combination of medications for individuals with co-morbid conditions. These circumstances could therefore require a variety of problem-solving techniques that our Coaches and Case Managers use to identify and help resolve barriers to adherence to their providers' medication regimens. In addition to proactively working with members to understand the importance of medication adherence, medication side effects and how to manage them, APS also works with members to ensure that they understand the importance of medication storage as well.a good foundation and continuum of care for health care services, appropriate access to current therapies and treatment regimens, as well as adherence to individual treatment plans. One a member is engaged, we work with them to verify if he/she has and is comfortable with his/her PCMH. If a member does not have a PCMH, we will help the member and identify a provider within the State network. Once the PCMH is established and entered in CareConnection, we contact each enrolled member's designated PCMH to coordinate management of the member's care and hold one-on-one discussions. Members can also identify specialty practitioners involved in their care and access can be granted for these providers to also have access to CareConnection®

APS also proposes to provide Medical Home with a roster of their individual members through one of two cost-effective, secure, and efficient methods: web-based access to member rosters through APS CareConnection®; and receiving a password-encrypted email on a monthly basis containing a list of their patients participating in the program. All member information concerning including their medical care will be communicated in alignment with HIPAA

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requirements. We will also determine if they would like training on CareConnection and if they are interested in clinical education related to improving their care.

In addition, APS will analyze the State's pharmacy claims data to identify members who are non-adherent based upon their MPR and provide feedback to the prescribing provider through our Patient Health Brief (see **Exhibit Q**).

### **Access to Provider Portal**

One of the greatest benefits of APS CareConnection® is that providers and APS staff are able to see the same information about the member. APS CareConnection® offers an historical view of the member across multiple episodes of care, and includes all of the information related to their case management activities.

Furthermore, the member's provider can view the member's entire clinical history and approve plans of care. As a result, APS CareConnection® acts as a vehicle for communication between our Case Managers, Case Managers and their physician to better coordinate care for the member. We believe that there is no other company that offers providers the ability to view such a complete record of member activity as well as approve the member's plan of care.

### **(I) Coordination with providers and State vendors; and**

#### **Coordinating Patient Selection with the Health Plan**

APS has established numerous interface protocols and data exchanges on behalf of our clients with benefit vendors such as Thomson-Reuters, Cigna, United Healthcare, Caremark, Blue Cross Blue Shield of (BCBS) of Alabama, BCBS of Georgia, BCBS of Idaho, BCBS of Montana, Accordant, Aetna, ValueOptions, Inc., University of Michigan, Hewitt, Express Scripts, Wells Fargo, ACS, Intracorp, Catalyst Rx, Walgreens and Paramount to name a few – in order to coordinate services. These interfaces include multiple systems and sources and include the export and import of various types of data files, including claims, pharmacy, eligibility, laboratory, incentives and Health Questionnaire data. We are extremely flexible in the development of successful interfaces in order to ensure the most comprehensive and coordinated care possible for the members we serve.

To ensure program success and meet the State's service integration requirement, APS employs proven service integration protocols with our customers' external vendors as well as their internal health initiatives to establish multi-service programs that are seamless to members, resulting in simplified program management for our customers.

Based on our experience with other plans APS proposes to carve out a subset of the top 20% highest cost/ highest risk members - those with the *highest ongoing risk for future high service*

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*utilization and impactable conditions.* We propose a methodology that guides this selection, and will then engage in a focused planning effort with the State to further refine selection criteria. Once selected, this population will remain in the complex case management program for the one-year contract periods. All care coordination and care management services will remain within the purview of APS, to avoid the typical problems that accrue with these populations when there are multiple clinical handoffs. All service and clinical data will be available to the State staff and to the State-approved providers and vendors on a real-time basis.

### **Integration of Utilization and Case Management Services**

As a specialty health care company who provides integrated utilization review and case management services, we understand the importance of coordination between the two programs. Utilization review staff are ideally positioned to identify members for case management at the point of service request.

As part of the implementation process, APS will establish effective interface protocols between the State's Case Managers and your vendor partners for coordination of case management and utilization review/management services. APS typically receives an electronic authorization file via secure FTP or fax of those individuals who have been approved for services for case identification purposes. This will enable our Case Managers to proactively reach out to these members for potential case management services. We typically request authorization data on a daily or weekly basis.

### **Benefit Integration / Establishing "Just In Time" Interfaces**

APS works in close partnership with our members' and their healthcare partners to ensure program expectations are aligned; that each party fully understands each vendor's respective services; and to develop a process for coordination necessary to best meet our member's expectations and goals. To ensure a systematic, yet flexible, interface exists between all parties, we take the following steps:

- Designating vendor and member liaisons to ensure each party has accountable and knowledgeable resources, who can clarify questions, resolve issues quickly and provide consultation for complex or special cases
- Foster cross understanding between participating parties regarding respective companies (e.g., history, mission, philosophy, etc.)
- Educate each other about the programs we currently deliver/will deliver
- Define clear roles and responsibilities
- Establish seamless interface protocols (e.g., cross-referrals, coordination of care, follow-up, etc.), including establishing "warm transfer" procedures to ensure members do not

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have to repeat clinical information more than once and ensure they are satisfied with the care they receive

- Establish follow-up procedures
- Identify potential joint opportunities to enhance coordination of care.

We also provide our member's other healthcare vendors with materials on our programs and referral information to encourage both electronic and telephonic cross-referrals. Our goal is to develop the appropriate interface protocols to ensure clear lines of communication are adopted for continuity and to optimize outcomes for all members and their families.

**(m) Copies of published studies or research that provide evidence that your case management interventions are effective.**

Copies of published studies are provided in **Exhibit O**.

**C.16. Review the scenario below and respond to each of the questions. Please provide as much operational detail as possible in your response in order to illustrate with a case example the mechanics of the programs that you described above.**

**Scenario: James is a 41-year-old male with no history of chronic disease, but he self-reports that he uses tobacco, and that he is largely sedentary. His biometric results indicate elevated cholesterol, and various pieces of information suggest that he may be pre-diabetic. Explain how your process would work, assuming that he took the health questionnaire on January 15 and the biometric screening in May 2. Please provide exact dates for each contact or intervention. Please also explain what pieces of information that you would use to make a preliminary conclusion that he is pre-diabetic.**

James registers for the Partnership PPO during open enrollment. James completes the Health Questionnaire online on January 15, 2011, which results in a Preventive Care Plan and an immediate health lifestyle and risk score of LOW to MEDIUM. On January 18<sup>th</sup>, James receives an email reminding him to complete his health screening including instructions on how to schedule an appointment at his worksite, and how he will be provided with a complete summary of results and a health-wellness score/risk assessment upon completion of the health screening. James will then receive an outreach call on January 21<sup>st</sup> by his designated Health Coach in compliance with the seven (7) day requirement.

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### January 21, 2011 - Initial Outreach Call

Based on the completed Health Questionnaire information, James will appear in the priority outreach list as MEDIUM to LOW risk within APS CareConnection as a result of our Percolator<sup>SM</sup> process. During this call, James' Health Coach will:

1. Introduce him/herself, explain her role, and provide James with her contact information.
2. Verify that James' information including his contact information and program eligibility is correct.
3. Review his health questionnaire results, review his MODERATE risk score and some of the health questionnaire feedback such as quitting smoking, having his blood pressure and cholesterol checked as well as assessing his readiness to exercise.
4. Complete the general assessment to verify whether his risk level is correct, assess physician information, additional medical history, and basic biometrics such as blood pressure (BP), BMI, tobacco use, substance abuse, alcohol use and physical activity. APS CareConnection will begin developing a suggested plan of care that both the Health Coach and James will agree upon together including what goals James would like to work towards.
5. Assess his appropriateness for either the lifestyle management program or disease management program based on his health questionnaire data risk score as well as the Health Coach assessment. This includes developing James' recommended plan of care with completion of the general assessment. Specific goals such as providing education to James on tobacco cessation, weight loss (BMI of 31 based on James' self reported information during the assessment), increase his physical activity, and for James to obtain a flu shot.
6. Enroll James in the Obesity Disease Management program integrated with the tobacco cessation program for lifestyle issues and explain her expectations regarding his engagement in the program. This includes reiterating to James that he will continue to receive the premium discount and lower out-of-pockets costs as long as he is an active participant in the Obesity Disease Management program since he signed the "Partnership Promise" during open enrollment. While the Health Coach will inform James of his right to disenroll at any time and how to disenroll from the program, she will also remind him that if he chooses to disenroll, he may become ineligible for the Partnership PPO program and be enrolled in the Standard PPO, which has higher premiums, deductibles, and coinsurance.
7. Verify that James has the program's toll-free number, hours of operations and the member website address. This includes explaining the nurse line services available through his benefits.
8. Explain the importance of contacting her if he experiences any medical or medical-related changes as well as if he changes his phone number.

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9. Verify James' preferred mode of communication (e.g., phone and/or email).
10. Schedule her second outreach call with James for February 8, 2010, and thank James for taking the time to speak with her.

- Action items for James:
  - i. Encouraged to complete his health screening. The Health Coach will provide him with information on how to identify health screenings and sign up for one online.
  - ii. Complete one (1) educational lesson within his tailored "My Health Lessons" within eDoc4U on the State's Member Web Portal.

### February 8, 2011 – Second Outreach Call

James is contacted a second time to continue building his plan of care. The focus of this call is to complete the obesity and tobacco cessation assessments. His Health Coach will also use motivational interviewing techniques to meet James where he is in the behavioral change model and use trained interventions to assist James in moving towards setting a quit date and to begin to discover James' eating patterns and motivation to change. The Health Coach will also remind James to complete his biometric screening again, review his action items and schedule the next call.

- Action items for James resulting from the call:
  - I. Contact his physician and discuss an exercise plan since he has been predominantly sedentary and has not exercised.
  - II. Begin to journal his eating patterns. The Health Coach explains that an online journaling feature is available to James through the State's Member Web Portal, and provides instructions on how to access the journaling feature.
  - III. Complete an additional educational item within the eDoc4U program that is tailored to him based on his health questionnaire results.
  - IV. Complete his health screening.

### March 1, 2011 – Third Outreach Call

James' Health Coach has contacted him and discussed his progress with completion of the two online educational modules and contacting his physician. James has not yet contacted his physician nor begun food journaling, but has completed both educational modules. The Health Coach discusses James' motivation to change and begins to discuss barriers to change such as being too tired after work, family obligations, and his hobby of e-bay surfing for two (2) hours a night. They began to discuss incorporating at least 15 minutes a day of walking such as parking in a parking spot that is further away from his office building, or walking down his drive way and back. The Health Coach also provides James with a food journal via mail to begin documenting his eating patterns. James is in agreement with this and decides that he could begin walking 15

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minutes a day as soon as he gets home from work each day. James is not too sure about quitting smoking at this time as he has tried to quit before but has failed. The Health Coach again urges James to have his health screening completed, explaining the health and financial benefits of fulfilling the Partnership Promise he made during the enrollment period, and the consequences of future ineligibility for the Partnership PPO benefit as well as increased premiums, deductibles, and coinsurance.

- Action items for James resulting from the call:
  - I. Contact his physician and discuss an exercise plan/clearance for exercise
  - II. Complete a health screening
  - III. Continue to work on the online program educational modules
  - IV. Begin his food journaling

### April 21, 2011 – Fourth Outreach Call

James is contacted by his region's/worksite's Health Educator to check his progress. James reports he has an appointment with his physician on April 26<sup>th</sup> and his physician will complete his biometric screening at that time. A follow up call scheduled on May 6, 2011.

### May 6, 2011 – Fifth Outreach Call

James is contacted to discuss his progress. The Health Coach is able to see his biometric data within APS CareConnection® that shows his health screening was completed on May 2, 2011. Based on the results, there are some concerns that the Health Coach would like to discuss with him. James' LDL is high at 189 and his fasting BSG is also elevated at 146. Along with his BMI of 31 and these elevated numbers, James' risk for diabetes is elevated. James also reports that the physician encouraged lifestyle changes such as diet and exercise to help with his elevated BSG and cholesterol. Additionally, James reports that he would need to schedule a cardiac stress test within the next week or two. James and the Health Coach discuss these risk factors and James provided the Health Coach with his physician's name and phone number for her to contact to obtain physician input into his plan of care. James is beginning to see the effects of his failure to exercise and poor eating habits. The Health Coach also reiterates the importance of smoking cessation because of the cardiovascular changes that take place such as increased cholesterol and higher risk of stroke. James agrees to have the Health Coach reach out to his physician to discuss his ability to exercise and nutritional needs. A follow up call scheduled in four (4) weeks to discuss James' stress test results and physician input.

**Three months after being enrolled in the module or program on the continuum of Health Coaching and health management services, you receive a notice from James' medical third party administrator that he is being released from the hospital. What follow up action would you take?**

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Shortly after the May 6<sup>th</sup> conversation, James was admitted to the hospital via the ER for chest pains. One of the State's medical carriers, Cigna, provides APS with a list of admitted members and James has just been discharged. On May 11<sup>th</sup> the Health Coach calls James to discuss his hospital visit. James reported that on Sunday May 8<sup>th</sup>, he was feeling lightheaded and fatigued all day. When he arrived home from church that day, he began experiencing chest pains that he thought were heartburn; he took some antacids and they didn't help. At that time his wife suggested he go to the ER. James was held for 24 hour observation and it was determined he did not have a heart attack, but had significant coronary artery blockage. James had a stent placed during a cardiac catheterization procedure. Based on this information, James will be moved into a case management level of care to ensure he has his needs met such as medications, understanding of discharge instructions, and to encourage physician collaboration. Short frequent contacts by his Health Coach are made weekly with (a minimum of one every month) to provide appointment coordination, education, and monitoring around James' follow up care.

The Health Coach provides education around cardiac catheterization, and reviews his discharge instructions to ensure he understood his follow up instructions. James was also prescribed a statin to help reduce his cholesterol and was instructed to follow up with a cardiologist in one (1) week. Follow up is scheduled for one (1) week to ensure a cardiologist appointment was made and to coordinate if needed.

**You eventually learn that James suffered a massive heart attack and is having a slow recovering and has not returned to work. What types of action would you take (if any)?**

We would have had ongoing outreach to James even with diminishing engagement on his end we would have continued engagement via provider liaison and claims analysis which would show if James was making and keeping appointments and getting appropriate 3 month supplies of his prescriptions. During a follow up call to James on July 12<sup>th</sup> to discuss James' progress relating to daily walking and nutrition, James' wife informed the Health Coach that he had a heart attack and has not been doing well. She reported that James had a heart attack on June 28<sup>th</sup> and is feeling very depressed and extremely tired. She reported that she found his prescription bottles mostly full, so while he filled them he did not take them. James and the Health Coach talk and the Health Coach completed the PHQ-9 with James to determine his depression risk. James score is a 14 and the Health Coach recommends that he follows up with his physician as well as provide support to let him know it is normal to be experiencing some depressed moods after a major medical event, but that he may need some additional counseling or medication. James agrees that he needs some additional help and feels overwhelmed with needing to quit smoking, exercise and change his eating habits since he has lived that way for a long time. The Health Coach understands this and helps James to

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understand that it will take time, establishing and completing one goal at a time, but is glad to hear he is feeling a bit more motivated to change. They talk about prescription adherence and its importance, and the Health Coach recommends a prescription dispenser. Additionally they discuss his support systems, diet, and any financial concerns. They discuss local support groups and online resources. Weekly calls will focus on one goal at a time including first getting depression treatment and adherence to all prescriptions on every interactive outreach.

**Eight months later, after James has returned to work, he reports that he has stopped using tobacco and brought his cholesterol down. He is also engaging in some limited physical activity each day. Explain your triggers and process for transitioning James to less-intensive levels of service (either now or in the future).**

Based on the ongoing assessment process with James, the Health Coach is able to identify positive movement with James. For example earlier on James had set specific goals to be educated on tobacco cessation, set a quit date, weight loss (BMI of 31 based on his self reported information during the assessment), increase his physical activity, and obtain a flu shot.

Unfortunately James had a series of events that triggered a major life event and with his Health Coach/Case Manager providing the support, coordination, and education he needed during perhaps the most difficult time of his life, he was able to identify barriers, learn journaling techniques to identify patterns to change, learn the technique of goal setting and that it is alright to take small steps to get to the desired goal point.

Based on the goals James has achieved as well as the ongoing claims data and uncoordinated care gap analysis monitoring for uncoordinated care such as medication gaps (poor refill patterns or missing evidenced based guideline medications) and testing compliance (such as LDL-C), the Health Coach will transition James to a level of care most appropriate for James. Lifestyle management / weight management would be most appropriate for James considering he has quit smoking, his cholesterol is down, and is engaging in light exercise each day. With each goal obtained and James reporting he feels better now that he is not smoking, a continued plan of care can be built to increase his physical activity to the recommended guidelines with his physician's approval as well as continue to incorporate healthy eating habits to decrease his BMI.

James will continue with the same Health Coaching team he began with, but at a less frequent level of contact. Contact will be made at a minimum every other month with the understanding that James may contact his Health Coach team at any time for questions or concerns.

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**C.17. Describe your clinical management software capabilities to document individual treatment/care plans, member communication with coaches/case managers, and continuity between coaches/case managers. Please discuss only those capabilities that you will use under this Contract.**

**In addition, describe what, if any, in-field biometric monitoring (e.g., glucose monitors, blood pressure monitoring, or scales) that you will make available to complex patients who participate in disease management or case management under this Contract. Which specific members, if any, will have access to these resources? Is automated data transmission available?**

### **APS CareConnection - The State's Health Management & Wellness Solution**

In order to effectively deliver the State's Health Management & Wellness Program, APS will employ our innovative, proprietary, web-based software solution, known as APS CareConnection. The APS CareConnection platform will functionally integrate data (health questionnaires, health screenings and nurse line data) from our subcontractors - Edoc4U, Summit Health and Carenet - to deliver a seamless service to the State's public plan members while providing the State with all pertinent data and information. Our platform offers our clients, like the State, a highly developed and HIPAA compliant system that is highly configurable to specific state requirements, effectively meeting each client's program needs.

One of the most significant benefits to APS CareConnection is that it represents a single source of member information. It captures and documents all services offered and provided to members as part of the Health Management & Wellness program and houses all relevant disease and care management tools – data, guidelines and criteria, plans of care, health status assessments, communications, and interventions – in a single site that is accessible to all providers, public plan members and APS clinical staff. This integrated resource promotes the type of productive interactions that are essential in the Chronic Care Model and support provider teamwork.

Through APS' systems platform, we can effectively integrate population health management service information with various types of data necessary to ensure the State's Health Management & Wellness program's success. Specifically, our systems platform provides a display of shared data that includes: medical and pharmacy claims, health questionnaire scores, health screening/biometric data, predictive modeling risk scores, chronic conditions, program engagement points, and gaps in care. By integrating this data within APS CareConnection, our Lifestyle Management Health Coaches, Health Coaches and Case Managers can see a 360 degree view of each member and can access the same member information for continuity of care. This improves the teamwork amongst the Health Management & Wellness services, and provides a seamless member experience.

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APS CareConnection, with its integrated plan of care, also represents an important resource for providers. It is offered to providers free of charge and no sophisticated software or hardware is needed for utilizing APS CareConnection – all that is needed is an internet connection. APS supports provider use of this resource with on-line help, a provider Helpdesk, and a locally-based Provider Relations Team. We will also provide training during implementation to ensure providers know how to use the system. Just as importantly, the Institute of Healthcare Improvement in Boston recognizes a plan of care for every patient as a key patient safety mechanism. The APS CareConnection plan of care, generated via proprietary algorithms based on best practice guidelines, can be maintained by both APS and providers and can be printed for signed, hardcopy storage if needed.

APS CareConnection is also compliant with many NCQA standards allowing APS to achieve its accreditation that much easier. As shown in **Exhibit U**, APS CareConnection meets element standards for Case Load Management, Client Demographic and Eligibility Information, Patient Dashboard, Episode Level – Outreach Activities, View All Notes, Provider Screen, Assessments, Individualized Plan of Care, My Follow-Ups, Activity Interaction Documentation, Individualized Treatment Plan, Education Module, Provider Portal to Support Client Activities, Plan of Care and Secure Messaging.

APS CareConnection has always been code-set compliant with HIPAA standards. We use standard ICD9 codes, and work closely with customers to resolve issues regarding the use of long-standing local code anomalies. APS will work with the State and the providers in the state to ensure that all code set needs are met. Our experience with our large base of providers and customers has taught us that the HIPAA standards are not completely uniform; one trading partner's definition and use of fields may vary significantly from another's. Many trading partners use optional fields to transfer information not covered in the standard, but needed to successfully transact the business. APS has a strong tool set and development team ready to successfully address these issues. Using BizTalk and custom programming, APS is confident we can meet the State's needs while complying with the federal standards and guidelines.

Supporting major functional areas of the State's Health Management & Wellness Program, APS CareConnection will feature the following advantages:

- Outreach policies and procedures will be documented in APS CareConnection and will record each communication/contact between our staff (Health Coaches/Case Managers) with members, providers, and community resources regarding program information and operation.

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- Personal Health Questionnaire and health (biometric) screening results from health screening events will be recorded and accessible to all Health Coaches assisting a State member.
- Assessments performed by APS Health Coaches and Case Managers that can be viewed by any authorized provider, based on system permission configurations, on an ongoing basis as treatment and progress ensues.
- Members' individual plans of care, that include goals and interventions based on assessments and clinical progress reports, allow providers and their staff to review and approve care plans, and closely monitor member patterns.
- Members' Personal Health Record including Health Questionnaire and health (biometric) screening results, medical and pharmacy claims will be available.
- Member Education Services include instruction given to members on appropriate use of health care services; risk-reduction and healthy lifestyles; self-care and management of health conditions; and advanced directives.
- Member Reminders serve as tools to signal office staff to follow-up on laboratory work, schedule appointments and can be configured at the member level based on long-term member goals.
- Member Profiles and an Automated Drug Use Review Alert Program notifies providers as to whether a patient is actually refilling his/her medications as prescribed and utilizing appropriate sources of health care service.
- Links to Clinical Guidelines, Protocols and Member educational materials are offered in several quickly accessible locations on APS CareConnection. In addition, providers will be able to see State branded health education materials, as well as links to information from nationally-recognized clinical organizations to support providers' own office-based disease management projects and general member education initiatives.
- Provider Feedback Reports and Member Record-Keeping Tool show how each participating provider is performing on chronic illness measures such as HbA1c and lipid levels. Information also includes differences between recommended care, actual care and care by other providers with a similar population. The Patient Record-Keeping Tool includes data on drug therapy compliance, utilization of emergency rooms and hospitals, laboratory assessments, and other trend data on the member's health status.
- DM Registry Look-Up Tool enables providers to be able to view, print, and download a list of active DM program Enrollees who have chosen the provider as their PCP. Our ability to collect eligibility data will facilitate this process.

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### In-Field Biometric Monitoring and Reporting – Health Buddy®



APS will provide Health Buddy®, an in-home biometric reporting tool from which we can monitor the member's condition, for the State's complex members who participate in our disease and/or case management programs. Specifically, we propose to offer the Health Buddy® tool to the highest risk members. Awarded the **Best Product by Business Week** and **Best Enabling Tool by the Disease Management Association of America**, the Health Buddy® appliance is a personal, easy to use, in-home communication and monitoring appliance with automated data transmission. The Health Buddy® appliance collects biometric data (e.g., blood pressure) that gives APS' Health Coaches important and timely information about a member's condition.

Using the device, members receive a series of questions (Health Dialogues) about their condition and will answer the questions by pushing one of four buttons on the Health Buddy® appliance. The Health Dialogues include responses to the participant's answers that can provide information, education, or reinforcement to the participant regarding his or her behaviors. The responses to the Health Buddy® questions can also include messages that prompt the participant to action. For example, a participant's response may prompt them to contact their PCP/therapist for an appointment.

Once the participant has answered the questions, the Health Buddy® transmits the information to APS CareConnection to assist APS' Health Coaches in tailoring their interactions with participants. Through the daily use of Health Buddy®, APS is able to promote self-management skills and behavioral change in enrolled individuals. The Health Buddy® also proactively identifies complications, allowing our Health Coaches to intervene at an early stage.

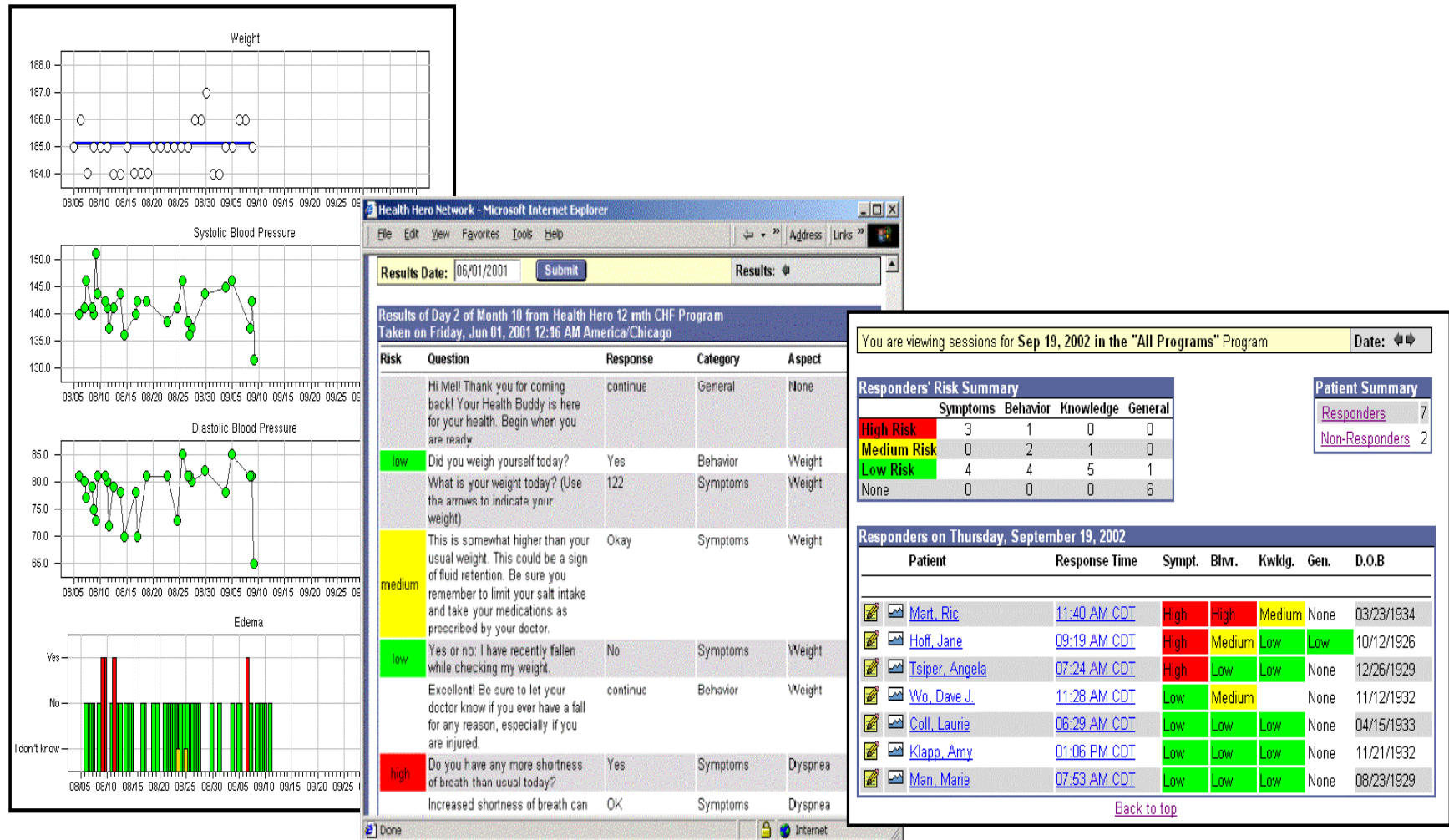
Below, we have provided illustrations of some of the data/reports that are available to our Health Coaches via the Health Buddy®.

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**C.18. Describe the specific performance measures you will use for this Contract to measure the percent and numbers of people who graduate from the program(s) in which they are enrolled, the percent and numbers of people who show behavioral changes and/or clinical improvements in accordance with their individualized goals.**

APS has provided a sample of performance measures that we propose to use for the State's program to measure the percent and number of people who show behavioral changes and/or clinical improvements in accordance with their individualized goals as well as those who graduate from our programs. A graduate is defined as "a participating member who has met defined condition-specific goals as established between the member and his/her coach after an appropriate number of coaching sessions. The member has demonstrated his/her understanding of the condition(s) and mastered the competency of self management of the condition(s). The member will still be considered participating but at a lower level of necessary engagement."

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Disease	Clinical Measure	Graduation Criteria
<b>COPD</b>	<ul style="list-style-type: none"> <li>Number and % of participants using inhaled bronchodilator (COPD pharmacotherapy) within 30 days of the event for COPD exacerbation.</li> <li>Number of admissions/1,000 members with a primary diagnosis of COPD.</li> </ul>	<ul style="list-style-type: none"> <li>No COPD - related hospitalizations or Emergency Room visits in past 12 months.</li> <li>Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>Member understands and verbalizes the importance of bronchodilators for COPD treatment.</li> <li>Compliant use of inhaled bronchodilator for past 12 months</li> <li>Member verbalizes understanding of controlled breathing methods</li> <li>Member obtains pneumonia vaccination to reduce risk of respiratory infections)</li> </ul> </li> </ul>
<b>Coronary Artery Disease (CAD)</b>	<ul style="list-style-type: none"> <li>Number and % of participants using prescribed beta blocker post acute myocardial infarction (AMI) for 180 days (HEDIS) after discharge.</li> <li>Number and % of participants who have annual LDL-C screening</li> </ul>	<ul style="list-style-type: none"> <li>No cardiovascular - related hospitalizations or Emergency Room visits in a year.</li> <li>Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>Member verbalizes importance of Beta Blockers for CAD treatment.</li> <li>Compliant use of beta-blockers for past 12 months</li> <li>Member reports blood pressure within recommended range at each phone call</li> <li>Member completes annual LDL-C testing</li> </ul> </li> </ul>

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Disease	Clinical Measure	Graduation Criteria
		<ul style="list-style-type: none"> <li>Member reports LDL-C results are within control range</li> <li>Member able to report the recommended frequency with which they should obtain LDL-C lab checks</li> </ul>
<b>Asthma</b>	<ul style="list-style-type: none"> <li>Number and % of participants with persistent asthma with at least one dispensed prescription for asthma controller medication (e.g., inhaled corticosteroids, cromolyn/nedocromil sodium, leukotriene modifiers or methylxanthines) (HEDIS)</li> <li>Number of inpatient admissions/1,000 patients with a primary diagnosis of asthma.</li> </ul>	<ul style="list-style-type: none"> <li>No asthma -related hospitalizations or Emergency Room visits in a year.</li> <li>Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>Member verbalizes importance of asthma medications (e.g., Leukotrine Modifier, inhaled steroids) for treatment</li> <li>Compliant use of controller medication for past 12 months</li> <li>Member completed Asthma action plan with physician</li> </ul> </li> </ul>
<b>Diabetes</b>	<ul style="list-style-type: none"> <li>Number and % of participants with at least one annual Hemoglobin A1C (HgbA1c) test. (HEDIS)</li> <li>Number and % of participants with annual fasting lipid profile (LDL-C). (HEDIS)</li> </ul>	<ul style="list-style-type: none"> <li>No diabetes or cardiovascular related hospitalizations or Emergency Room visits in a year</li> <li>Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>Member completes at least quarterly HgbA1c and LDL-c test annually</li> <li>Member demonstrates HgbA1c control</li> <li>Member verbalizes understanding of regular</li> </ul> </li> </ul>

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Disease	Clinical Measure	Graduation Criteria
		blood sugar monitoring
<b>Heart Failure (HF)</b>	<ul style="list-style-type: none"> <li>Number and % of participants with HF with at least one prescription for an ACE or ARB.</li> <li>Number of admissions/1,000 members with a primary diagnosis of HF.</li> </ul>	<ul style="list-style-type: none"> <li>No cardiovascular or respiratory-related hospitalizations or Emergency Room visits in a year.</li> <li>Individualized patient goals met. Samples goals include: <ul style="list-style-type: none"> <li>Member verbalizes understanding of the importance of monitoring Ejection Fraction</li> <li>Member verbalizes understanding of AHA standards of care (e.g., daily morning weights, blood pressure control &lt;130/80, low sodium diet, smoking cessation, daily exercise, alcohol limited, avoidance of illicit drugs, routine lab work per physician orders, medication adherence, and flu shot/pneumococcal vaccine)</li> <li>Member demonstrates an ejection fraction &lt;40 on an ACE or ARB</li> <li>Member verbalizes an understanding of the importance of ACE Inhibitor/ARB for HF treatment</li> </ul> </li> </ul>
<b>Depression</b>	<ul style="list-style-type: none"> <li>Number and % of newly diagnosed and treated participants who remained on an antidepressant medication (acute phase treatment) for 12 weeks (84 days).</li> <li>Number of admissions/1,000 members</li> </ul>	<ul style="list-style-type: none"> <li>No behavioral health-related hospitalizations or Emergency Room visits in a year.</li> <li>Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>Member verbalizes understanding of depression</li> </ul> </li> </ul>

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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Disease	Clinical Measure	Graduation Criteria
	admitted to the hospital with a primary diagnosis of depression	<ul style="list-style-type: none"> <li>management</li> <li>○ Member no longer receives psychotherapy treatment</li> <li>○ Member verbalizes importance of medication adherence and has successfully incorporated medications into his/her lifestyle</li> <li>○ Member is compliant with prescribed antidepressant medication (meets the acute and continuation phase treatment requirements)</li> </ul>
<b>Musculoskeletal issues (i.e., low back, osteoarthritis)</b>	<ul style="list-style-type: none"> <li>■ Number and % of members demonstrating understanding of role of posture, lifting, body mechanics.</li> <li>■ Number of Emergency Room visits/1,000 members for low back pain.</li> </ul>	<ul style="list-style-type: none"> <li>■ No pain-related hospitalizations or Emergency Room visits for low back pain in a year.</li> <li>■ Patient has had appropriate diagnostic testing completed</li> <li>■ Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>○ Member verbalizes understanding of their musculoskeletal condition</li> <li>○ Member increases number of symptom-free days per week by 10% from initial baseline</li> </ul> </li> </ul>
<b>Morbid obesity</b>	<ul style="list-style-type: none"> <li>■ Number and percent of members with BMI greater than 40 engaged in the Obesity Program</li> </ul>	<ul style="list-style-type: none"> <li>■ Individualized patient goals met. Sample goals include: <ul style="list-style-type: none"> <li>○ Member verbalizes the NHLBI Standards of Care (national heart lung blood institute) for weight management</li> </ul> </li> </ul>

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## A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

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Disease	Clinical Measure	Graduation Criteria
		<ul style="list-style-type: none"><li>○ Member verbalizes an understanding of components of a healthy diet by incorporating them into their diet</li><li>○ Member verbalizes their caloric intake level based on Food Pyramid (decreasing daily caloric intake by 500-1000 calories)</li><li>○ Member demonstrates BMI less than 40.</li><li>○ Member engages in moderate-intensity exercise 30 minutes most days of the week</li><li>○ Member achieves reduction in body weight of 10% after approximately six (6) months of therapy (weight should be lost at 1-2 pounds per week)</li></ul>

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**C.19. With respect to your work under this Contract, to what extent will you incorporate patient decision-making tools (e.g., DVDs, etc.) that attempt to empower participants to make informed choices regarding various treatment modalities (e.g., physical therapy versus back surgery, prostatectomy versus radiation therapy, diet and exercise versus different bariatric procedures, etc.)? Which decision aids do you believe are the most effective? What evidence about the efficacy and cost-effectiveness did you use to guide your decision in this regard?**

APS realizes the best healthcare decisions are made when patients understand their options. APS partners with Krames, a leading provider of patient education and health education solutions, as well as the Healthwise® Knowledgebase to deliver patient decision-making tools as part of the State's Health Management & Wellness Program. All information is designed to empower State members in helping them make the most informed decisions regarding their health and treatment options, and will be easily available through the State's member web-portal.

### **Krames: Proven Decision Support Tools**

Krames' decision support is created using health literacy design principles in an effort to increase self-efficacy—driving positive behavior change that improves member health status and satisfaction while lowering utilization costs. Information available to State members will include downloadable fact sheets (see samples as **Exhibit R**), as well as videos that can be viewed online or requested in a DVD format.

Content includes the pros and cons of various treatment options including physical therapy verses back surgery, prostatectomy versus radiation therapy, as well as diet and exercise versus different bariatric procedures, for example. All decision support tools undergo Krames' rigorous medical review process to ensure efficacy and accuracy and contain both clinical and self-management treatment options, facilitating better understanding during patient-provider treatment discussions.

APS strongly believes that Krames' thorough development process is the basis for some of the most effective patient decision making tools in the industry today. A dedicated team of in-house staff:

- Researches subject matter by compiling information from an on-site medical library and clinically recognized government institutions and academies including the U.S. Food and Drug Administration, Centers for Disease Control and Prevention, National Institutes of Health, Occupational Safety and Health Administration, College of Obstetrics and Gynecology, and American Dental Association.
- Works in conjunction with medical experts who are specialists in their respective fields.

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- Conducts formal surveys to gather feedback from professionals and end users.
- Gathers feedback from peers and industry thought leaders through conferences, meetings and trade shows.
- Conducts content validation and approval and a technical review whereby a team of practicing specialists reviews the draft content.

Additionally, specialists are chosen based on prominence in specialty field; association with the nation's leading universities, teaching hospitals and healthcare organizations; and geographical location for a diverse, balanced representation in the product review.

### **Evidence and Outcomes**

Many of Krames' decision support materials are produced on an 8.5" x 11" format, a format which is cost-effective and user-friendly for all State members. The efficacy and positive effect of Krames' decision support tools on well designed health management and wellness programs has been validated through numerous recent studies. For example, the use of Krames Patient Education materials helped to deliver better health outcomes and subsequently lowered costs when used as part of a Heart Failure education program at Del Sol Medical Center. The study, part of the Robert Wood Johnson Foundation's *Expecting Success* Program which focuses on addressing health disparities, delivered a 56% drop in readmissions (from 16% to 7%).

### **Healthwise: Supporting More than 60 Million Healthcare Decisions Annually**

Similarly, APS strongly supports the efficacy and quality of Healthwise's decision support tools. Given that Healthwise's in-depth, decision focused health information has been accredited by the URAC Health Web Site Accreditation Program and is available online, we believe it is an effective and easily accessible decision-making tool. Healthwise's informational tools can be highly personalized, and are delivered to the individual member as part of the process of care, with only the information relevant to his or her current clinical status. By ensuring that the member is receiving only the most relevant information for him/her, there is less confusion on the part of the member, and they are able to play a more active role in their own care.

The Healthwise® Knowledgebase is:

- Decision-focused to help members make important diagnostic and treatment decisions;
- Action-oriented for managing the daily issues of the disease;
- Demographic- and time-specific for zeroing in on the exact moment in care members are dealing with;
- Comprehensive and in-depth for every aspect of the disease, as well as virtually every other health concern; and
- Easy to use.

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Through the Healthwise® Knowledgebase, the State's members will have access to various types of decision-support information, including but not limited to Decision Points—an easy-to-use, interactive tool that provides members with comprehensive decision-making support on available care options. The tool balances facts with individual preference and values to help members take an active role in their health by determining which treatment or care plan may best suit their needs. It can help members take a more active role in their health, be more informed, and communicate with their providers.

Each Decision Point will guide State members through a comprehensive decision-making process.

Decision Points can be found in the Health Tools section and the Treatment Overview section of the

Healthwise® Knowledgebase. Help with the decision-making process is available on 158 topics for sensitive decisions including surgery, medication, and medical testing. At the end, members can print a personalized summary. A sampling of topics is included in the table below:

A Sample of Decision Point Topics	
Should I have radiation therapy or a prostatectomy for localized prostate cancer?	Should I have magnetic resonance imaging (MRI) for low back pain?
Should I have spinal manipulative therapy for low back pain?	Should I use a diet plan to lose weight?
Should I have shoulder replacement surgery?	Healthy aging: Is it time to stop driving?
Should I have catheter ablation?	How can I make informed decisions about my extremely premature infant?
I have diabetes. Should I get pregnant now?	Should I (or my child) have surgery for scoliosis?
Should I bank blood before surgery?	Should I bank my baby's umbilical cord blood?
Should I be tested for hepatitis B and C?	Should I breast-feed my baby?
Should I consider a multi-fetal pregnancy reduction?	Should I consider adoption as an alternative to infertility treatment?
Should I get a flu shot?	Should I get a hearing aid?
Should I get a pacemaker for heart failure?	Should I get an insulin pump?
Should I give my child antibiotics for an ear infection?	Should I have a coronary calcium scan to check for heart disease?
Should I have a dual-energy X-ray absorptiometry (DEXA) test to diagnose	Should I have a gene test for breast and ovarian cancer?

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A Sample of Decision Point Topics	
osteoporosis?	
Should I have a hysterectomy and oophorectomy to treat endometriosis?	Should I have a prostate-specific antigen (PSA) test to screen for prostate cancer?
Should I have a sleep study to diagnose obstructive sleep apnea?	Should I have a surgical procedure for varicose veins?
Should I have a tubal procedure or in vitro fertilization for tubal infertility?	Should I have a VBAC trial of labor after a previous cesarean?
Should I have a wisdom tooth removed?	Should I have allergy shots for allergies to insect stings?
Should I have an amniocentesis?	Should I have an early fetal ultrasound?
Should I have an angiogram to test for coronary artery disease?	Should I have an autopsy done on my loved one?

## Evidence and Outcomes

Healthwise supports the goals of APS' customers by helping to keep members healthy and on the job; reducing unnecessary health care visits, treatments, and costs; and increasing member satisfaction. Members make more than 60 million healthcare decisions annually with Healthwise's resources. Studies supporting the effectiveness of decision-making tools and Healthwise, specifically, are listed below:

- Decision aids like Healthwise Decision Points are particularly important for complex health decisions that have multiple options, risks, or benefits as well as scientific uncertainties and cost differences. Expert perspectives suggest that decision aids have the potential to improve quality and efficiency in the health care system<sup>4</sup>.
- A Cochrane Collaboration review of 55 randomized controlled trials of shared decision making found that patients who used such decision aids had greater knowledge about their treatment options, were more actively involved in the process of deciding on a treatment, and were more satisfied with their decision and the process. "...Patients who used decision aids were about 20% less likely to choose invasive surgical options over more conservative ones, without a negative effect on outcomes."<sup>5</sup>
- A Cochrane review identified trials of seven conditions commonly treated surgically among the Medicare population: arthritis of the hip and knee; low-back pain from a herniated disc; chest pain (stable angina); enlarged prostate (benign prostatic hypertrophy, or BPH); and early-stage prostate and breast cancer. The review documented that although the uptake of surgery following shared decision making

<sup>4</sup> Weinstein J, Clay K, Morgan T (2007). *Informed patient choice: Patient-centered valuing of surgical risks and benefits*. *Health Affairs*, 26: 726–730

<sup>5</sup> O'Connor AM et al. Cochrane Database Syst Rev. 2003;[1]:CD00143

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(compared to control groups) varied from study to study, a 21 to 44 percent decrease was typical<sup>6</sup>.

The Cochran database also noted that Healthwise provides more International Patient Decision Aids Standards (IPDAS)-compliant patient decision tools than any other consumer health information company. The IPDAS Collaboration is a group of researchers, practitioners and stakeholders from around the world.

**C.20. Describe your process for engaging or re-engaging poorly adherent Partnership PPO members who are enrolled in lifestyle management, disease management, or case management programs under this Contract. In addition, describe your strategies for this Contract to re-engage participants who disenroll from lifestyle management, disease management, or case management.**

APS is extremely experienced in engaging members in both our commercial and Medicaid programs. In fact, we've had great success in engaging Medicaid members who represent some of the most difficult populations to locate and engage. This experience with a hard to find, hard to motivate population has given us tremendous experience in driving individuals to action. APS will leverage our experience in both the commercial and public sector to 1) engage and re-engage poorly adherent Partnership PPO members who are enrolled in lifestyle management, disease management, or case management programs under the State's Health Management & Wellness program; and 2) re-engage participants who have disenrolled from lifestyle management, disease management, or case management. Our goal is to deliver a comprehensive service that reaches as many members as possible and helps them effectively change their at-risk behaviors and adopt sustained healthy behaviors.

Strategies to engage and/or re-engage Partnership PPO members will leverage multiple contact channels – direct mail, telephonic, onsite, online and provider outreach. All strategies (excluding provider communications) will emphasize the health and financial benefits of maintaining an “active” Partnership PPO status, including the premium and benefit differentials in the plans. A variable-channel approach provides the mechanism to deliver supporting messages to others affected by a member's decision (i.e. spouse) as a point of leverage to encourage re-engagement, improved adherence, or participation of the spouse/dependent themselves. Our strategies are outlined below:

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<sup>6</sup> O'Connor AM, et al. (2003). *Decision aids for people facing health treatment or screening decisions*. Cochrane Database Systematic Reviews (2)

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## In-home Direct Mail

Communications mailed to the member's home for engagement will include:

- "Unable to Reach" postcard to those members who haven't responded to APS' telephonic outreach attempts for program enrollment.
- Treatment/Care gap notification for those members who haven't completed recommended activities based upon standards of care for their identified conditions (e.g., a diabetic who may not have had their annual A1C test). This message can be inserted on the member's birthday postcards that we will send out.
- Program reminder/savings reminder that reinforces the Partnership PPO and the activities members can participate in to fulfill their Partnership Promise. These can be delivered mid-year or between the 3<sup>rd</sup> & 4<sup>th</sup> Quarter.
- On-site program alerts and reminders (i.e. health screenings; education sessions; health fairs; wellness challenges) as appropriate

For those individuals who have "disenrolled," APS will also send a mailer to the member's home that explains the benefits of the Partnership PPO and to re-engage with their Lifestyle Management Health Coach/Health Coach before year-end so that they are still eligible for continued financial savings of Partnership PPO program (lower deductible, coinsurance) as well as potential health benefits.

## Telephonic Engagement

APS commonly uses a combination of live and automated telephonic outreach to deliver targeted and population messages. Use of both direct Health Coach outreach and automated call technologies will be used as stand-alone attempts and within integrated campaigns to engage or re-engage Partnership PPO members. Outreach and campaign application to include:

- Our **Health Coaches outreach** to members for enrollment, post-enrollment assessment and ongoing follow up. A Health Coach will outreach to EVERY State member who participates in an onsite educational event, health screening event and/or completes a Health Questionnaire to review their results and ensure appropriate follow up. Health screening and health questionnaire results are uploaded into our health management platform, APS CareConnection, facilitating the availability of information at the fingertips of our Lifestyle Management Health Coaches, Health Coaches, Health Promotion Coordinators and Member Services Representatives. This enables our staff to make the most of each and every member interaction. In accordance with the State's requirements, APS will make and document at least four (4) attempts to contact the member by phone over a period of two (2) weeks at varied times of day, followed by a letter sent to the member's most recently reported address.

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- **Automated call technologies** will be employed in addition to Health Coach and In-Home Direct Mail. Content of this telephonic messaging can be targeted and customized based upon the specific needs of the State's members. For example, based upon the results of the health screening or health questionnaire, we can send automated messages to those members who have high cholesterol levels to engage them with a Health Coach so that they can begin to make the appropriate steps to improve their health. We have taken a similar approach with the State of Ohio to improve engagement rates. Other applications of our automated call technologies to include:
  - Care gap/preventive notifications
  - Quarterly or mid-year program reminder/savings reminder
  - On-site program alerts and reminders i.e. health screenings; education sessions; health fairs; wellness challenges)
  - Program re-enrollment "opportunity" (frequency/persistence to be determined with the State)

For those individuals who have "disenrolled," APS will also utilize automated call technologies to contact these members, explain the consequences of forfeiting the Partnership PPO benefit (increased coinsurance, deductible), and invite them to re-enroll by calling their Lifestyle Management Health Coach/Health Coach/Case Manager directly or the program's toll-free number.

### **On-site Engagement**

On-site events, while typically passive, provide another opportunity to seek out active and inactive Partnership PPO members, eliminating perceived barriers and placing a "face" to the program. On-site events, health screenings, wellness challenges, and brown bag educational sessions provide the opportunity to engage and re-engage members in their health, perform assessments, and address health concerns and establish goals. We will seek to understand the variability in Tennessee's diverse and unique employee population (i.e., demographics, education, work-site, shift, job type). On-site programs are developed to meet members where they are, and when they are available.

Our onsite engagement approach will be spearheaded by the States' Health Promotion Coordinators who are the foundation for program promotion, outreach and sustained active program engagement. Specifically, your Health Promotion Coordinators will be responsible for promoting all components of the Health Management & Wellness program through worksite brown bag educational presentations, health fairs and health screening events. The worksite education provided during brown bag educational presentations, health fairs, and health screening events are extremely effective because at the time of the worksite Health Management & Wellness service, the Health Promotion Coordinator can immediately refer potential candidates to the appropriate chronic disease management, wellness/lifestyle

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behavior change coaching program or case management program. They can also re-engage Partnership PPO members who have already enrolled in lifestyle management, disease management, or case management programs, but are not adhering to the "Partnership Promise" by explaining the importance of such programs in terms of improving the member's overall health as well as the cost savings aspect of the Partnership PPO plan and their possible ineligibility for the next enrollment period if their commitments are not met. Our Health Promotion Coordinators can easily provide the member with information on how to access their health questionnaire and help them identify and schedule a health screening event during their face-to-face contact.

Health Promotion Coordinators can also link them with their Health Coach/Case Manager for re-engagement in the relevant program. For example, *at a recent health fair for our client the State of Ohio, APS screened 85 of the State's members and made 41 Health Coach referrals – close to a 50% referral rate.* These in-person interactions are perfect opportunities to speed the outreach and enrollment process, providing education at the point-of-care about program benefits and linkage or re-linkage with necessary services. APS Health Promotion Coordinators will attend EACH Tennessee event to distribute detailed program information, promote the Health Questionnaire and Health Screenings, gather referrals and update members' demographic information with accurate contact information (i.e. phone numbers, home addresses and email addresses). APS will use this same strategy for those individuals who have disenrolled in lifestyle management, disease management, or case management programs.

Additionally, our use of "Site Champions" at the State's various worksites will also help to engage and re-engage State members. During the implementation process, we will identify in collaboration with the State's specific representatives (e.g., Human Resources, Managers/Supervisors, etc.) key staff at your worksites who will be essential to program promotion and assisting your greater workforce. These internal staff will be responsible for answering member questions about the program, connecting members with coaching or other services as appropriate, and a resource for them while completing their health questionnaire and screening. Given their natural presence within the State's workplace, the Site Champions will be able to regularly interface with the State's members to continually reinforce the program's message, explain the benefits of program engagement and improving their health, and encourage them to engage or re-engage in the program. During the implementation period, APS will train the State's designated Site Champions so that they can educate the State's members about the program and act as available resources to members to ensure the promotional campaign remains effective and encourage engagement.

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## **Online Engagement**

Tennessee's Partnership PPO and Standard PPO members will have access to an expansive set of online tools (i.e., health questionnaire, goal setting and tracking, health education, self-directed lifestyle and wellness programs). To support ongoing utilization and adherence, these programs provide frequent e-mail reminders, tips, and encouragement. The application of more current social media technologies (i.e., Twitter; Facebook) will also be employed as a mechanism to deliver messaging, reminders, and encouragement to engage in the State's Health Management & Wellness program. As an "opt-in" channel, the State's members will also have the opportunity to select and de-select electronic communications.

## **Provider Engagement**

APS understands that providers can be one of the most influential channels to program participation and adherence. APS performs direct outreach to providers of our enrolled members. The two primary communications vehicles are:

- Provider notification – The notification letter identifies the patient (PPO member) and their enrollment into a health management program, outlines services and benefits, and provides program contact information.
- Patient Health Brief– The Patient Health Brief provides an alert to providers if patients/members are in need of preventive care, are non-adherent to medication, are admitted to the hospital and identifies other providers engaged in the member's health care.

Additionally, APS CareConnection also affords providers online access to their patients Plan of Care, medication histories, diagnoses, and a coordinated plan of care which will assist the provider when interacting with these members.

**C.21. Describe the monitoring program for lifestyle coaching, DM and case management calls under this Contract. For example, is there a 100 percent review or random sampling; two-way silent monitoring, one-way monitoring, taped calls or some combination? State the percentage and frequency of calls that will be monitored for this Contract for each of the three program types: lifestyle coaching, DM and case management.**

## **Monitoring Call Performance of APS' Staff**

APS is committed to conducting internal quality assurance monitoring to ensure the highest quality Health Management & Wellness program services are provided to the State's plan members. As part of our quality assurance program, APS monitors the call performance of both APS employees as well as employees of our subcontractor partners during interactions with members. Phone services monitoring will be conducted to ensure that efficient, customer-

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friendly services are provided by the State's Lifestyle Management Health Coaches, Health Coaches, Care Managers as well as Member Service Representatives. This includes silent monitoring as well as call recording for quality monitoring and training purposes. We monitor for the appropriateness of the information that is conveyed to members. The results are used as part of the staff member's annual performance evaluation and to identify quality improvement activities. In accordance with the RFP's requirements, 100% of calls will be recorded and indexed during the first three (3) months of the contract term; from the fourth month on, APS will record either ten percent (10%) of all calls or a statistically valid sample of calls depending on the State's determination. Of these calls, approximately 3-5 calls per month per staff member will be selected for monitoring for our entire Health Management & Wellness program including lifestyle coaching, disease management and case management calls. If our staff does not meet our 90% quality threshold, additional calls will be monitored until performance improves. Additionally, we will provide the State or its authorized representatives the ability to monitor calls remotely.

**C.22. Provide an example (annotated screen shots and narrative) of Web-based functionality that you propose to use under this Contract. At a minimum, include a description and screenshots of:**

- (a) The user registration and management process,**
- (b) Inquiry and response capabilities,**
- (c) Worksite screening event search/locator functionality,**
- (d) Worksite screening event scheduling,**
- (e) Disease management "portals" for at least two in-scope chronic disease states listed in Contract Section A.7.s.**

**In your descriptions/narratives, highlight aspects/features of your site/page design and associated functionality that you would characterize as strengths.**

### **The State's Web-Portal**

APS offers the State's members access to a fully integrated website, branded with the State's unique brand, "ParTNers for Health," which will contain various web-based content, tools and resources that support the State's Health Management & Wellness program and complies with the RFP requirements in Section A.12.k. The website functions as a comprehensive Health Management & Wellness platform, supporting the individual member across the entire care continuum with meaningful and easy to understand content and resources. The website includes general program information and content along with a high-touch, member-specific portal that is personalized to the individual member's health and wellness needs and can be accessed securely and confidentially via specific member accounts. As requested we have provided brief descriptions of our web-portal's capabilities below.

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## **User Registration and Management Process**

Through the secure and confidential member-portal area of the website, State members will be able to register and create a secure profile including a username and password. This will allow State members to complete the online registration form that will be required for all Partnership PPO members and any Standard PPO member enrolled in lifestyle management, DM or case management. APS understands that the content of the form will be provided by the State but assures the State that we can accommodate the following fields: member contact information, preferred method of receiving wellness score/risk assessment and other information; and primary provider(s) name(s) and contact information. We will ensure the online registration functionality will be in place on or before October 15, 2010. Additionally, once registered, State members will be able to access other member-specific tools including but not limited to an online health questionnaire and the ability to locate a health screening event and set an appointment.

## **Inquiry & Response Functionality**

State members will have access to a secure inquiry and response function whereby they can post general questions to APS, and receive appropriate responses in a timely manner. Our staff, which may include a Member Services Representative, Health Coach or Case Manager depending on the specific request, will be able to respond to general program questions as well as push relevant information (e.g., condition-specific and wellness tip sheets, etc.), health screening event updates and evidence-based practice guidelines to specific groups of members or to a specific member. Additionally, through the secure and confidential member-portal area of the website, State members will be able to chat with a Health Coach for additional resources and information.

## **Worksite Health Screenings – Event Locator & Scheduling Appointments**

The State's members will be able to easily look up and schedule health screenings through the Web portal. Once a member is registered, the online appointment system allows them to look up screening events in the online appointment book, select a location and time, and be put on a waiting list for a specific time slot if their first choice is not available. They can also note special requirements (e.g., wheelchair) if necessary. The member then receives a confirmation of the time, date, and location of their health screening event. An email reminder is also sent the day before the event to reduce no-shows. Members can also view results of their health screening online.

Online appointment scheduling has resulted in increased member satisfaction as it nearly eliminates waiting lines at the screening event. Additionally, as most individuals sign up quickly upon receiving the email invitation, the APS' Health Promotion Coordinator will know a week or more in advance what the expected turnout will be, and if low, can increase the internal

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awareness campaign. The power and flexibility of this on-line appointment system differentiates Summit Health, Inc. from other biometric screening providers.

### Member-Portal

Through the State's website, your members will be able to access various tools and content specific to them via the Member Portal. The Member Portal will allow them to access such information in a secure and confidential manner via their specific member account/profile.. Features of the Member Portal include:

- **Disease Management Portal:** The State's website will include a disease-specific portal for diabetes and heart disease. Specifically, this area of the website will include disease-specific content such as:
  - Tip sheets on various conditions (e.g., medication management, recommended practices and activities, etc.)
  - Provider office checklists
  - Physician screening forms
  - Individualized feedback to members who complete the health questionnaire via their Preventive Care Plan (described below).
  - Links to other industry recognized websites (e.g., American Diabetes Association, etc.)
- **Health Questionnaire:** State members will be able to access, complete and make changes to his/her Health Questionnaire, which results in an electronic and printable customized preventative care plan, personal wellness program/online coaching information, and a personal health record. Additionally, a clinical access portal where approved providers can review results of their patient's health questionnaire. This area of our member portal is a particular strength of APS' offering as it offers members access to a complete comprehensive web-based preventive care program that supports five (5) ethnicities with cultural competence sensitivity. All of these components – from the Health Questionnaire to the Preventive Care Plan to the Personal Health Record - are integrated to share appropriate member data and disease prevention analysis and Disease Risk Index conclusions. The Preventive Care Plan is based on data collected by the Health Questionnaire and Personal Health Record, while the member specific Online Health Coaching is based on the Disease Risk Index conclusions also based on the member specific Health Questionnaire and Personal Health Record. These features are described in greater detail below:
  - **Health Questionnaire:** An intuitive health questionnaire, utilizing "branching logic", creates a unique clinical pathway for each member. Self-reported information is captured by our "smart browser interface" during a 10-15 minute on-line member session as well as physician updates and real-time client data transfer. The health

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- questionnaire interactively integrates member medical risks and biometrics with lifestyle, mental health and injury prevention. Current health questionnaire variables include; age, gender, ethnicity, personal and family health history, medications, allergies, biometric, screening test history, nutrition, physical activity, readiness to change, substance use, mental health and injury risks. Biometric and clinical laboratory values are evaluated in conjunction with screenings.
- **Preventive Care Plan (PCP):** Highly personalized, culturally sensitive and easy-to-understand Preventive Care Plans are delivered to members for interactive participation. Evidence-based Best Practice guidelines and ethnicity-based predictive modeling are used for accuracy and culturally appropriate presentations. Members receive recommendations for disease prevention, healthy lifestyles, self-care and injury prevention, along with their risk evaluations for: coronary artery disease, diabetes, high blood pressure, stroke, obesity, depression, asthma, colon cancer, breast cancer, cervical cancer, prostate cancer and testicular cancer. Recommendations and disease risks include 'trusted physician' video counseling, action lists, educational information, and ability to manage in 'real time', enforcing on-going behavioral change for better health. The "Schedule Me" function also provides the ability for the member to request Preventive Care procedures to be scheduled through an affiliated hospital.
  - **Personal Wellness Program/On-line Coaching (OLC):** A personalized lesson plan is generated based upon the member's disease risk indexes. Lessons are organized around health education, stress management, nutrition, exercise & fitness and personal development. Each lesson is a 10-15 minute multi-media educational experience, and includes a quiz to measure comprehension. The lesson plan also tracks open and completed lessons with date of completion.
  - **Personal Health Record (PHR):** The PHR supports the Continuity of Care Record (CCR) format for compatibility and is totally integrated with the HRA and PCP for automated data collection. The PHR is an outward facing tool that collects the patient's history of screening tests, medical conditions, medical procedures, medications, allergies, immunizations and healthcare contact information. Password protected clinical access, email communications and download options places PHR ownership and control in the member's hands.
  - **Clinical Access Portal:** Through the Clinical Access Portal, health care providers are provided with patient access to Protected Health Information on a patient-by-patient and group-by-group basis. As a result, approved members of a group's health care team have the ability to review patient recommendations and disease risks.

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- **Health Journals/Logs & Trackers:** Through our Member Web-Portal, State members will have access to online journaling tools for exercise, blood pressure, blood sugar and cholesterol as well as a food diary/nutrition tracker and log (*see Question C.23 below for more details*).
- **Self-Care Resources:** Member can access self-care resources such as illustrated medical encyclopedia, patient reports on diseases & wellness topics, medical animations, pregnancy and body guides.
- **Calculators:** Calculators include BMI, calories burned, target heart rate, ideal body weight and nutritional needs.
- **Wellness Point Tracker:** This feature will allow State members to verify and track the number of wellness points they have accrued (*APS will implement this feature upon direction from the State*).
- **Patient decision aids:** This area will include fact sheets, videos and a list of DVDs on various topics (e.g., back treatment options, diet and exercise versus different bariatric procedures) along with information on how to request DVDs.

Additional features of our website include:

- Member-oriented educational and outreach materials (e.g., tip sheets condition specific education materials; health education videos; interactive workbooks) including information about specific health management and wellness services available to members.
- Frequently asked questions (FAQs) and answers area.
- Instructions on how to access health management and wellness services;
- Program contact information (i.e., mailing address, email, member services and nurse advice line telephone numbers, and fax number)

Screen shots of the requested pages are provided in **Exhibit S**.

**C.23. Describe the features and ease of use of the online journaling and the other types of online and paper-based tools you propose to use pursuant to Contract Section A.12.k. Please provide sample materials to the extent possible.**

Through our Member Web-Portal, State members will have access to online journaling tools. Online journaling includes a food diary/nutrition tracker and logs for exercise, blood pressure, blood sugar and cholesterol as detailed below:

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- The food diary/nutrition tracker provides journaling for meals by type, portion and calories.
- Exercise log stores physical activities for flexibility, cardiovascular exercises and strength training.
- Blood pressure log tracks systolic and diastolic compared to normal ranges.
- The blood sugar log provides daily tracking of glucose levels and periodic entry of HbA1c levels for diabetics.
- The cholesterol log tracks total, LDL, HDL and triglycerides.

Sample screen shots (using a fictional member and data) of our online journaling tools are provided below:

SCREEN SHOT CONSIDERED PROPRIETARY & CONFIDENTIAL

**Date**

Start

End

**Intensity**

☒ High Intensity

☒ Medium Intensity

☒ Low Intensity

**Exercise Type**

☒ Flexibility

☒ Cardiovascular

☒ Strength Training

Selected Date Range: 4/1/2007 - 4/10/2007

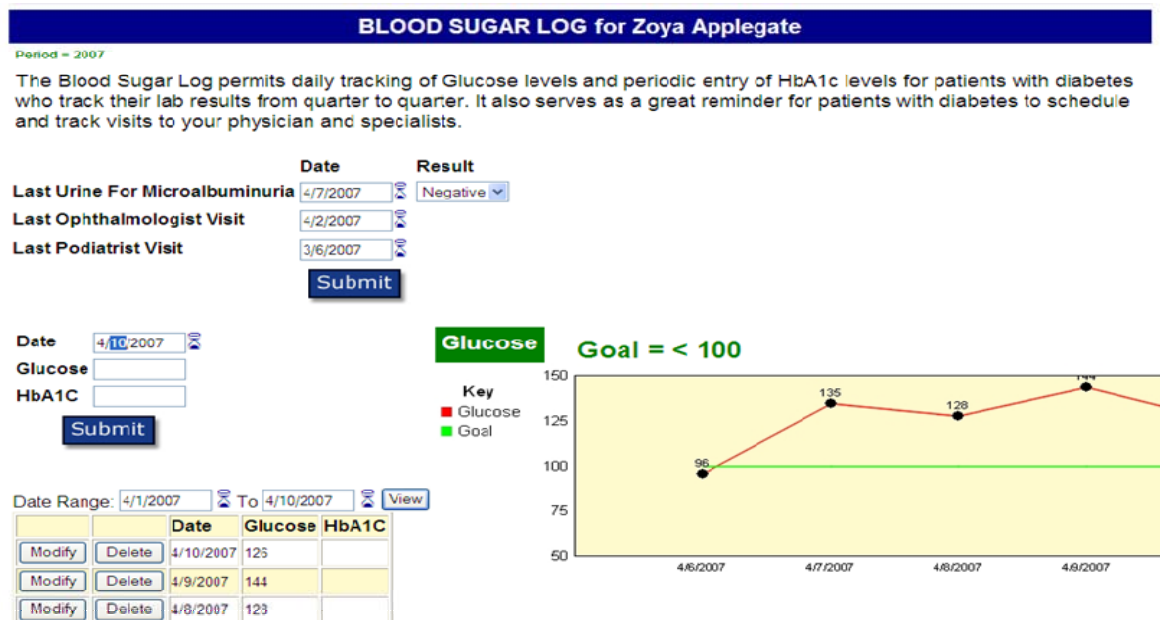
Zoya Applegate - 4 Events 750 Minutes total

Date	Flexibility	Cardiovascular	Strength Training
	<ul style="list-style-type: none"> <li>Gardening - 30 min (Low Intensity)</li> <li>Household Chores - 45 min (Low Intensity)</li> <li>Stretching - 15 min (Low Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Aerobics - 20 min (High Intensity)</li> <li>Cardio Workout - 20 min (High Intensity)</li> <li>Tread Mill - 30 min (High Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Abs - 10 min (Medium Intensity)</li> <li>Arms - 20 min (Medium Intensity)</li> <li>Back - 10 min (Medium Intensity)</li> <li>Legs - 15 min (Medium Intensity)</li> </ul>
4/6/2007	<ul style="list-style-type: none"> <li>Walking - 30 min (Pedometer - 4500 steps) (Low Intensity)</li> </ul>		
	<ul style="list-style-type: none"> <li>Gardening - 15 min (Low Intensity)</li> <li>Household Chores - 60 min (Low Intensity)</li> <li>Stretching - 15 min (Low Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Cardio Workout - 30 min (High Intensity)</li> <li>Tread Mill - 30 min (High Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Abs - 10 min (Medium Intensity)</li> <li>Arms - 10 min (Medium Intensity)</li> <li>Back - 10 min (Medium Intensity)</li> <li>Legs - 10 min (Medium Intensity)</li> </ul>
4/4/2007	<ul style="list-style-type: none"> <li>Walking - 30 min (Pedometer - 4500 steps) (Low Intensity)</li> </ul>		
	<ul style="list-style-type: none"> <li>Gardening - 30 min (Low Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Cardio Workout - 20 min (High Intensity)</li> </ul>	<ul style="list-style-type: none"> <li>Abs - 10 min (Medium Intensity)</li> </ul>

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**C.24. Describe or provide the following information about data reporting under this Contract:**  
**(a) the Proposer's standard reporting package, inclusive of report names, numbers of reports, methods of distribution, and refresh frequency, and whether the reports required by the Pro Forma Contract are included;**

Collecting and utilizing meaningful, accurate and timely data is one of the most important foundations for any APS program. Our Corporate Reporting Division is responsible for developing comprehensive reporting packages – both standard and ad hoc - that detail each program's activities and performance, and assist them in achieving their program's specific goals and objectives. APS draws clinical intelligence and workflow assignments from our web-based, program management solution, APS CareConnection®, which captures and houses individual member information, as well as our relational databases to configure many combinations of data elements to develop both standard and ad hoc reports.

Our Reporting staff utilizes the Seagate Crystal Reports software package, which is designed specifically for identifying, accessing, analyzing, and sharing what is important from among the millions of pieces of information contained in relational databases. APS uses Seagate Crystal Reports for query and development of reports. Seagate Crystal Reports is the industry standard

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software product most widely used for reporting, accessing, and analyzing data. This software allows for customized reporting so that information can be shared with others in a meaningful way. We use Crystal Enterprise to deploy reports to the web in a secure environment for instant customer access. APS also uses SAS as its primary statistical analysis tool.

As part of our normal program operations, APS provides each customer with a customized reporting package that addresses their specific needs. The reporting package is distributed at various frequencies (e.g., monthly, quarterly, annually) based upon contract-specific requirements. Reports are distributed to customers based upon their preference but can be delivered electronically (e.g., electronic mail, posted on a SFTP) as well as hard copy. As requested, we will submit Public Sector Plan-specific reports to the State electronically in your specified format and according to your required frequencies.

APS confirms we will provide reports that are compliant with those specified in the State's Pro Forma Contract using the reporting template prior approved in writing by the State. Our customized, comprehensive reporting package for the State's program includes 18 key reports, which will each be refreshed according to their required frequency submission. Specifically, the report will include:

1. **Performance Tracking**, as detailed at Contract Attachment B with each component be submitted at the frequency indicated in Contract Attachment B. The report will also be submitted by secure email that will include:
  - a. Status report narrative
  - b. Detail report on each performance measure
2. **Health Screening Completion Report (Monthly)**: The report will include, at a minimum, the number and percent of Partnership PPO members and Standard PPO members (by Plan type, e.g., State, Local Education, Local Government) who have completed the health screening since the commencement of the plan year by location of screening (e.g., employment worksite, provider-in-home)
3. **Employment Site Screening Event Report (Monthly)**: The report will include, at a minimum, the numbers and percent of Partnership PPO members and Standard PPO members who have completed the health screening at an employment worksite with a map tracking the number of events and the number of screens conducted at each employment worksite event
4. **Health Screening Summary Report (Quarterly)**: The report will include, at a minimum, information and data on the frequency of conditions such as high cholesterol, high blood glucose, high blood pressure and BMI status.
5. **Health Questionnaire Completion Report (Monthly)**: The report will include, at a minimum, the numbers and percent of Partnership PPO members and Standard PPO members (by Plan type, e.g., State, Local Education, Local Government) who have

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completed the health questionnaire since the commencement of the plan year; the number of hard-copy health questionnaires provided; and a narrative on steps APS has taken to encourage members to complete a health questionnaire.

6. **Health Questionnaire Summary Report (Quarterly):** The report will include, at a minimum, information and data on the frequency of lifestyle risks and chronic conditions by type.
7. **Participation Report (Monthly):** The report will include but not be limited to the number and percent of eligible members (by type of PPO) who are/are not participants (by active and inactive participation) by program (lifestyle management, DM and case management), risk level, and condition (e.g., weight management, COPD, transplant); information on participation by type of intervention; the number and percent of participants enrolled in one program who are receiving services from another program; number and percent of eligible members (by type of PPO) that could not be contacted; information on participants who graduated; and a summary of co-morbid conditions by condition.
8. **Voluntary Disenrollment Report (Monthly):** The report will include but not be limited to information on voluntary disenrollments, including the number and percent of members who signed the Partnership Promise and are disenrolling.
9. **Customer Satisfaction Report (Monthly):** The report will, at a minimum, report on compliance with the established customer satisfaction standards.
10. **Quarterly Grievances Report (Quarterly):** The report will, at a minimum, summarize the number of grievances, by type, the timeframes for resolving grievances related to disenrollment and those not relating to disenrollment, and the resolution.
11. **Call Center Statistics and Summary Report (Daily, Weekly and Monthly** on a schedule consistent with Contract Section A.10.d.(3)).
12. **Monthly Returned Mail Report (Monthly):** The report will, at a minimum, include the names of all members whose mail was undeliverable due to incorrect addresses provided by the State.
13. **Performance Measures Report (Quarterly and Annually):** The report shall, at a minimum, identify the performance measures used for each program/risk level, the methodology, the results, and proposed improvement activities.
14. **Health Screening Exit Survey Report (Monthly** during the period that APS holds employment health screening events): The report will, at a minimum, summarize the methodology and results and identify improvement activities.
15. **Program Satisfaction Report (Annually):** The report will, at a minimum, summarize the methodology and results and identify improvement activities.
16. **Account Team Satisfaction Survey Report (Annually).**
17. **BC-DR Results Report (Annually)**

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- 18. Program Participation Files Report** to medical TPAs and PBM (Monthly): The report will, at a minimum, include information on the members enrolled in lifestyle management, a DM program, or case management and be specific to each medical TPA.

APS will also provided additional reports, as specified in the State's Contract and using templates prior approved in writing by the State.

**(b) the type and duration of information systems and reporting tools training that the Proposer will provide State staff during implementation; the qualifications and credentials of the trainers; and whether the training can be performed on-site at a State location;**

APS will provide the State's authorized staff access to our Business Intelligence (BI) environment where they can access various types of program data to generate ad hoc reports. Training on the BI environment will be led by the State's dedicated Account Manager with support from your designated reporting liaison with the following types of qualifications

- Educational Requirements: Bachelor's degree in statistics, mathematics or computer sciences, information systems or related field, Master's degree, preferred.
- Minimum Qualifications:
  - Minimum of three (3) years of background in healthcare, risk management, insurance, statistics or related areas of expertise is required.
  - Experience with developing databases, analyzing data using standard software packages and preparing analytical reports is required.
  - Strong analytical and mathematical skills.
  - Proficient in MS Excel, MS Access, AQL and Crystal Reports.

Training on the BI environment will begin during the implementation process and continue during the first 60 days post go-live date to ensure your authorized staff understand how to access the system, the data sets and how to create reports. Your Account Manager will be available throughout the life of the contract to answer and/or field any additional questions regarding the BI environment to ensure your ad hoc reporting needs continue to be met. APS will also provide additional training as updates occur to our BI environment. Trainings can be provided onsite at a State location and via web-conference depending on the State's preference.

**(c) the generation and provision to the State of the key reports prescribed in the Contract (Section A.21 of the Contract);**

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APS' Reporting and Health Intelligence Department will be responsible for generating all key reports prescribed in the State's contract. Our Reporting staff will utilize the Seagate Crystal Reports software package to generate such reports as it is specifically designed for identifying, accessing, analyzing, and sharing what is important from among the millions of pieces of information contained in relational databases.

### **(d) The standard reports and related ad hoc reports that you would recommend and propose to provide under this Contract;**

While APS' standard reporting package is comprehensive and meets many of our customers' needs, APS is more than able to deliver ad hoc reports based upon each customer's preferences. For example, our Health Intelligence Division supports our Corporate Reporting Department and is responsible for analytics analysis and developing additional reports for customers. Working in tandem with our Corporate Reporting Department, our Health Intelligence Division accepts, processes and integrates large volumes of data (e.g., medical claims, behavioral claims, pharmacy claims, health risk assessment data, biometric screening data, laboratory results data, eligibility data, etc.) from a variety of sources to develop comprehensive reporting packages that meet the needs of our customers and assist them in achieving their program's specific goals and objectives. We routinely accept large medical, behavioral and pharmacy claims files as well as health risk assessment data, biometrics data and laboratory data (when available) for our disease management programs. This data is then integrated into analytic data marts that allow our Health Intelligence Division to conduct various types of data analyses (i.e., member identification and risk stratification for outreach, treatment gap analysis to identify clinical gaps in care, participation rates and outcome measures) as well as related reporting.

For example, for the Plan of Wisconsin, we completed more than 200 research and analytical projects each year providing detailed analyses on areas such as, quality monitoring and improvement, fraud and abuse auditing and assistance, and financial and eligibility forecasting. We also develop reports for the Oklahoma Health Care Authority (OHCA) that outline program statistics, such as utilization, expenditures and disease prevalence and targeted reports that focus on fiscal, political, and program engagement APS also develops and maintains executive information system reports to improve OHCA program management, and calculate performance measures to evaluate the quality of fee-for-service and primary care case management.

**THIS SPECIFIC EXAMPLE ABOVE IS FOR ILLUSTRATION PURPOSES ONLY AND WILL NOT BE PROVIDED TO THE STATE UNDER THIS CONTRACT FOR THE ALL-INCLUSIVE ADMINISTRATIVE FEEDS BID IN THIS RFP**

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As we do with these customers, APS will discuss and collaborate with the State to provide similar ad hoc reports and/or identify other types of reports that may be of use to the State during the implementation process and on an ongoing basis as your needs evolve.

**(e) the Proposer's ad hoc reporting capabilities— address State access to an ad hoc reporting liaison to assist in the development of ad hoc report requests as well as the extent to which authorized State staff will have access to the Proposer's system(s) for the purpose of creating and generate ad hoc reports;**

APS is able to produce ad hoc reports for each of our customers when requested as we are adept at responding quickly to data requests. In fact, our dedicated Reporting staff responds to over 1,000 ad hoc requests annually. Our Reporting staff utilizes the Seagate Crystal Reports software package, which is designed specifically for identifying, accessing, analyzing, and sharing what is important from among the millions of pieces of information contained in relational databases. Our team has a great deal of experience using the Seagate Crystal Reporting package, which is easily configured to issue reports on any number or variety of data elements, based on program specific parameters. The Seagate Crystal Reports software also enables the creation of standard templates that can be exported to Adobe PDF or Microsoft Excel. These standard templates both help enhance reporting productivity, ensure data integrity and make it easier for our clients like the State to access, view and share program results. Additionally, APS will designate a reporting liaison with APS who will be responsible for working with the State in developing meaningful and relevant ad hoc report requests.

APS can also provide the State's authorized staff access to our Business Intelligence (BI) environment to create and generate ad hoc reports. We have a powerful information delivery architecture that addresses our customers' information needs, and can do the same for the State. Our BI environment will allow the State's authorized staff direct access to various types of data and information related to the State's Health Management & Wellness program. The BI environment includes various layers and forms of data access to support the State's varied needs. For example, this includes but is not limited to pre-built dashboard-style graphs and gauges for performance management, ad-hoc query capability for spontaneous needs, and analytical drilldown tools for "slice-n-dice" information analysis. APS believes our BI environment will provide the State with a comprehensive pool of program data presented in the most user-friendly way to create meaningful ad hoc reports on demand.

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**(f) the payment reports that the Proposer will provide to the State to assist the State in reconciling payment detail and recording accounting entries.**

To assist the State in reconciling payment detail and recording accounting entries, APS will provide payment reports to the State. This report will detail fields including but not limited to the number of participants/employees, month of service payment, agreed upon rate per participant/employee, invoice number, and invoice date.

**(g) The ability in a secure, inquiry-only environment for authorized State staff and providers to view certain aggregate data and create and/or generate reports on an ad-hoc basis.**

As stated in **Question 24.e** above, APS is able to provide the State with access to our Business Intelligence (BI) environment, which is a secure, inquiry-only environment, to view program-specific aggregate data and then generate ad hoc reports as needed. The APS BI environment contains data in various formats, geared around information access needs. The data is transformed into meaningful information through enrichment, standardization, aggregation, and quality/cleansing. Access to the data is then granted to the State in a tiered security model that addresses privacy requirements. Customers, like the State, can be granted various types of access based on business needs, legal/privacy regulations and customer preferences/positions. The different access types consist of several dimensions ranging from how a customer can access data to what type of data can be viewed by whom. The underlying data is stored in a data warehouse and wrapped with a user-friendly "metadata" layer that hides the complexity of the data from the user, enabling easy access to understandable data.

**Please provide samples of all referenced reports and screen shots of all referenced online systems to which the State will have direct access.**

APS has provided our sample reporting package with all referenced reports as well as screen shots of our online reporting system that will be accessible to the State in **Exhibit T**.

**C.25. Describe or provide the following information regarding the call center infrastructure that the Proposer offers in the performance of under this Contract:**

In accordance with **Question 26** below, we have provided separate responses for APS' Member Services Call Center which will be located in Nashville, Tennessee or another in-state location as desired by the State. This Tennessee Service Center will house the State's Member Services Representatives, Lifestyle Management Health Coaches, Health Coaches and Case Managers.

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**(a) The operations of call center(s) including the location of call center(s), hours of operation, staffing projections, and plans for rerouting of calls and in what circumstances that may happen;**

### Member Services Call Center

APS will establish a Service Center in Tennessee that will house our Call Center operations for the State's Health Management & Wellness program. The hours of operations for the Tennessee Call Center will be 8:00 am – 8:00 pm CST, Monday through Friday. Approximately 89 positions will be staffed to meet the scope of work as outlined within the State's RFP. APS' Tennessee Call Center will be staffed with our team of Health and Lifestyle Management Health Coaches, Case Managers and Member Services Representatives, all of whom will receive comprehensive training on the State's Health Management & Wellness Program to ensure superior service to your members and providers. Our staff will also be trained on "warm transfer" protocols for public plan members as appropriate. This may include warm transfers to the 24/7 Nurse Line for triage, health information and/or health care decision support as well as the State's external vendors such as the member's medical TPA, the EAP/BHO, and the PBM as necessary. Additionally, the State's dedicated Member Services Representatives will be able to connect members with their appropriate Health Coach's/Case Manager's voice mail at their request.

To ensure Members and Providers are efficiently connected with the most appropriate resource, APS uses an Automatic Call Distribution system and phone tree that clearly identifies options for services, and immediately routes calls to the most appropriate staff member (e.g., Health Coach or Members Services Representative) to meet client needs. In accordance with the RFP's requirements, members can speak with a Lifestyle Management Health Coach, Health Coach, Case Manager or Member Services Representatives through a dedicated toll-free number. Members also have access to a separate dedicated 24/7 Nurse Line. After normal business hours, our Member Services Call Center's message will inform callers of the nurse advice line number, when to call that number (e.g., for after-hours triage), and provide the caller the option to directly connect to the nurse advice line.

In the event of call center failure due to events such as natural disaster or power outage, APS is well equipped and prepared to re-route calls of our Tennessee Call Center. Our Disaster Recovery/Business Continuity (DR/BC) Plan has procedures in place to re-route calls from our Tennessee Call Center to a back-up call center. We have a state of the art telephone-switching infrastructure that allows any call that cannot be delivered to its designated call center to be automatically rerouted to a backup center. We also have the ability to reroute calls on demand, should we need to shut down a call center before the normal end of the business day. APS believes these processes and preparation will minimize or eliminate disruption of service to the

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State's public plan members, and ensure the integrity of the data collected, despite brief periods of IT system failure. More details on our DR/BC Plan is provided in **Question 25(g)** below.

Please note that APS emphasizes recruitment of multi-lingual staff and access to translators to assist members when needed. For the State's public plan members, who do not speak English or who request language assistance, APS utilizes the Omni Network language line, with capability in over 150 languages for immediate access to telephonic language translation services, which are free of charge to members. Additionally, we will seek out and attempt to recruit bi-lingual staff (English and Spanish).

### **Nurse Advice Line Call Center**

APS has selected Carenet as our nurse line partner for the State's Health Management & Wellness Program. Carenet is headquartered in San Antonio, Texas and operates a state-of-the-art, URAC-accredited healthcare support center in the same location. Its center is operational 24-hours a day, 7 days a week, providing the State's public plan members with access to care at the most convenient time for them.

To deliver the Nurse Advice Line services, Carenet utilizes a shared model for both the non-clinical and the clinical teams where the staff is shared among all clients. This model allows Carenet to achieve maximum call center efficiency. This model also allows for sudden demand changes like an influx of calls and/or emergencies. With the shared model, we are able to meet the performance metrics for each program and the end result is a satisfied member. Using a shared model in our program delivery and our scheduling/forecasting process, Carenet has an agile staffing model, not restricted by life count capacity. Carenet uses call volume estimates and trending to prepare from both a staff and technology perspective.

Carenet will deliver nurse line services from its San Antonio facility and does not have plans for rerouting calls. Rerouting calls is a component of its Disaster Recovery plan outlined in **Question 25(g)** below.

**(b) The flexibility of the call center to handle fluctuations in call volume resulting from program, benefit or enrollment changes, and address related equipment, its scalability and flexibility, and the proportion of its capacity currently in use;**

### **Member Services Call Center**

APS has a wealth of experience successfully operating over twenty customer service centers located in North America and Puerto Rico and Hawaii. APS call centers receive over 850,000 inbound calls on an annual basis across all of our lines of business.

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APS utilizes Avaya systems to support our call center operations. Key features of the Avaya system that will support this operation are:

- 36,000 Busy Hour Call Completion Capability at Peak Load
- Up to 250 Call Center Agents
- Up to 100 Call Center Agent Supervisors
- Call Recording, Archiving and Web Based Retrieval Systems
- IVR and Text to Voice Capabilities
- Voice Mail Integration
- Real Time and Historical Customer Service Management Reporting and Alerting

In the unlikely event a local disaster were to render the call center incapable of supporting our clients, calls will be routed to our Brookfield data center.

APS systems are both extremely scalable and flexible, and are ready to comfortably handle normal call volume and exceptional operational conditions related to program, benefit or enrollment changes for the State's Health Management Program.

### **Nurse Advice Line Call Center**

Carenet fully understands that staffing on each of the line queues is of the utmost importance for the State and your members; therefore, it has taken the following steps to ensure all services are provided without interruption and Carenet is fully prepared to handle any influx in volume:

- Carenet staffs at 110% for its need
- Personal Time-Off (PTO) requests are required to be submitted up to 6 months in advance. This allows ample opportunity for the staff to select open schedule slots for coverage
- Absenteeism due to unscheduled/unplanned absences is managed by off-set shift start/end times. When an oncoming shift is missing someone unexpectedly, the previous shift workers are asked to stay until a replacement arrives.
- For situations where Carenet feels it will be short staffed due to illness, Carenet will first look for other members of the team to trade shifts.
- For extended illnesses on the nursing staff, Carenet's PRN (as needed) and PT (part-time) staff are called upon to pick up hours.
- For its RN staff, Carenet has a work-at-home program (Carenet@Home) that allows it to have flexibility for a short-staffed situation.

Carenet operates one healthcare support center located in San Antonio, Texas. The healthcare support center is designed to successfully respond to immediate increases in client growth

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potential by having 60-80 additional stations configured and ready for immediate use. Carenet also offers a work at home program for qualified staff – with nearly 60% of the staff taking advantage of this benefit. In addition, Carenet has staff co-located at client facilities where multiple partners are housed together in support of a single client.

All of these initiatives ensure that Carenet is ready at any moment to handle client growth or to accommodate volume fluctuations from current clients. When it comes to scaling facilities and resources, Carenet's collective experience is the industries best as each member of its team has played key roles in executing aggressive growth needs of clients for nearly two decades.

### (c) A sample of the call center statistics that will be available to the State;

#### Member Services Call Center

APS' call center operations are reported on a daily and monthly basis to senior management through an Automatic Call Distribution (ACD) report. The ACD report reflects the productivity of the call center and compares it against standards relative to a month-to-date total. APS call centers feature a sophisticated telephone system that enables us to meet all NCQA and URAC telephone access standards. As a result, APS is more than able to meet and report on the State's program call center statistics in accordance with your RFP requirements:

Measure	State-Specific Standard
Percent of calls answered by Person	One hundred percent (100%) of calls answered by a person within five (5) minutes (300 seconds)
Average seconds to answer (ASA)	less than one (1) minute (60 seconds)
Hold rate	After answering the call APS may only put callers on hold in order to (a) make outbound calls as necessary or (b) to research a caller's issue.
Blocked call rate	Less than one percent (1%) per each three-hour continuous period each day
Abandoned call rate	Not more than three percent (3%) for each respective morning, mid-day, and evening period

APS assures the State of our ability to successfully meet your expressed call center standards. In fact, we currently exceed many of your standards as evidenced by our Ohio Service Center, which also serves the State of Ohio's Health Management & Wellness program:

Measure	Ohio Service Center Results (Quarter 1, 2010)
Average Seconds to Answer (ASA)	7 seconds
Abandonment Rate	<2%

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### Nurse Advice Line Call Center

Carenet tracks and reports various call statistics to ensure efficiency, and confirm call center reports can be provided in accordance with the State's requirements. Call statistic reports include:

- Total Calls Answered
- Average Speed Answered (Seconds)
- Percent Service Level (percent of calls answered by person within specified interval)
- Total Calls Abandoned
- Percent of Abandoned Call
- Blocked Call Rate

Additional Nurse Line reports include:

- **Guideline Report** – This report is a summary of the guidelines used during triage calls and the number of times the guideline was used. The information can be sorted by timeframe and frequency of use.
- **Source Report** – This report is a summary of all calls by source used to track trends and year end statistics. The information can be sorted by timeframe and is distributed monthly as a PDF file. Excel or Word files available upon request.
- **Disposition Report** – This report is a summary of triage calls showing the total number of times recommended dispositions were used. The information is sorted by disposition acuity and frequency of use.
- **Disposition vs. Original Inclination Report** – This report is a summary of triage calls reporting the final disposition and the original inclination of the member. The information can be sorted by timeframe
- **Cost Avoidance Report** - This report is a summary of cost avoidance based on specific caveats. The information can be sorted by timeframe.
- **Triage Call Report** – This report is a summary of the encounter including the caller's problem, disposition, guideline used, and patient demographic information. The report is generated real time via secure fax or compiled and emailed daily. This report is stored indefinitely for access if appropriate. The report is in PDF format. Excel or Word files available upon request. Carenet documents all triage/health education encounters with client's members and reports those encounters "real time" to clients via HIPAA compliant electronic fax or the batch of encounters can be transmitted daily through an electronic feed.

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- **Gender Report** – This report is an analysis of callers by age and gender to measure trends. The report can track any timeframe except hourly. The information can be sorted by timeframe.

### (d) Call monitoring sessions regularly conducted by the call center or in coordination with the State;

#### Member Services Call Center: Monitoring Staff Call Performance

As stated in Question 21 above, APS monitors call performance of all our staff - Lifestyle Management Health Coaches, Health Coaches, Care Managers and Member Service Representatives - to ensure that efficient, customer-friendly services are provided to the State's public plan members. Specifically, we will conduct silent monitoring sessions as well as call recording for quality monitoring and training purposes. APS will also coordinate with the State to facilitate remote call monitoring by the State or its authorized representatives as required by the RFP.

#### Nurse Advice Line Call Center: Monitoring Staff Call Performance

Carenet's Quality Assurance Program measures the accuracy of its assessments, effectiveness of the interaction, adherence to and meeting contractual objectives, and program results. Carenet focuses on:

- Clinical/Product Integrity – safe and appropriate recommendations and adherence to regulatory standards and established guidelines
- Effective/Quality Call Processing – providing the highest quality of service to the maximum number of patients while being respectful of the patient's time

In order to gather data by which to measure quality, one hundred percent (100%) of both inbound and outbound calls are recorded. An analysis of randomly selected recorded calls is conducted each month for each client and quality assurance reports are produced that include call volume, specific client issues, and program results. The reports are reviewed by Carenet's Quality Committee, led by its Executive Vice President and Medical Director, who follow a logical sequence of steps including thorough analysis of problems and identification of potential causes. Modifications are made to the program when necessary to ensure success.

Remote monitoring will be facilitated by providing a supervisor license and user interface to the State's associate(s) that require monitoring access. With this license level the State associate will be able to log onto Carenet's system (after complete system authentication) as a remote supervisor and listen to calls just like Carenet's supervisors in the contact center. This remote user access is a standard feature of Carenet's telephony.

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In addition, Carenet invites the State's team to establish regularly scheduled calibration sessions where representatives from both teams will monitor calls together and calibrate on the scoring process.

### **(e) Capabilities to accommodate hearing and visually impaired members;**

#### **Member Services Call Center**

Our call center staff also has access to TDD and local relay services to communicate with callers who are deaf or hard of hearing, 24 hours a day, 7 days a week. Additionally, APS' educational materials will be available in alternative formats (e.g., large print, Braille, audio tapes) to accommodate visually impaired members as we have done this for other contracts. We would like the opportunity to meet with the state during implementation to fully understand your expectations so that we can meet the needs of your visually impaired members.

#### **Nurse Advice Line Call Center**

Carenet has the capability and TDD equipment to handle calls for deaf/hard of hearing members. All staff is trained on the process and knows how to effectively communicate with deaf/hard of hearing members during their time of need.

Carenet relies on the caller to be its eyes when describing health issues or symptoms they are experiencing. As a result, for visually impaired members, Carenet's staff is trained on how to effectively ask probing questions to obtain the necessary information.

### **(f) Information systems support for the call center member services representatives, including tracking calls/correspondence and access to other data (e.g., claims data, provider information);**

#### **Member Services Call Center**

Member Services Representatives will have access to all non-clinical functions of our web-based information system, APS CareConnection®. APS CareConnection®'s capabilities include correspondence tracking between our staff and the State's members so that we can see what types of information have been sent. Additionally, Member Service Representatives will have access to other types of data such as benefits information in order to answer members' benefit questions accurately and with confidence (e.g., program eligibility questions), contact information for the State's other vendor partners to facilitate "warm transfers" to the member's medical TPA, the EAP/BHO, and the PBM. This also includes "warm transfers" to the nurse line as well as the member's Lifestyle Management Health Coach/Health Coach/Case Manager if he/she is already enrolled in our program. Additionally, Member Services Representatives will be able to document inquiries and complaints in APS CareConnection®. Furthermore, Member Services Representatives will have access to the State's web portal so

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that they can help them schedule health screening appointments, complete their health questionnaire, and explain the various types of information and tools available on the web portal.

### **Nurse Advice Line Call Center**

Carenet uses CareEnhance® Call Center (CECC) software from RelayHealth®, a McKesson company, to deliver the program. Carenet utilizes the CECC suite of software products including the Nurse Triage, Customer Relationship Management, and Provider Service modules. The software solution provides a central access point for all services as well as a single data repository for patient information.

The CECC triage module is equipped with the most trusted clinical content in the industry and provides the decision tree functionality used by Carenet's nurses when delivering care.

The system improves clinical outcomes by providing safe and clinically proven information to patients, and provides more than 400 triage guidelines, access to more than 1,000 consumer-focused health topics, and 1,500 of the most commonly prescribed over-the-counter medication topics. The triage guidelines were specifically written about adult, women's health, behavioral health and pediatric health topics. The pediatric content is authored by the pioneer of telephone triage, Dr. Barton Schmitt. Carenet's call center software has a rigorous clinical review process to ensure superior clinical advice. Carenet's Medical Director also reviews annual updates and changes. The decision tree matrix followed by the nurses begins with gathering information from the patient and continues through the triage assessment and questions. The result is a disposition and care advice provided to the patient. The guidelines are updated annually.

In addition to CECC, Carenet utilizes Healthwise Connect, a clinical application that supports the RNs conversation with the member on the phone. The application provides various call-center specific features to promote efficient content access and validation of services, and runs on top of the Healthwise Knowledgebase body of consumer health information content. Healthwise content is rigorously reviewed by nationally recognized specialists from throughout the United States, Canada, and Europe. The Healthwise Knowledgebase includes 8,000 topics ranging from symptoms, health conditions and disease to complementary and alternative medicines.

Healthwise Knowledgebase includes a drug interaction checker that will help the RNs assist patients with making better health decisions about their medicines. Another feature of the Healthwise Knowledgebase is the 150 Decision Points that provide the framework and information that the patients can use to make wise health decisions about tests and treatment options.

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**(g) Back-up call center operational readiness in the event of a natural disaster, etc.**

**Member Services Call Center: Disaster Recovery/Business Continuity Plan**

APS has a Disaster Recovery/Business Continuity Plan in place to effectively provide back-up call center operations in the event of a natural disaster for example. A central part of this plan is our state of the art telephone-switching infrastructure. Utilizing extensive routing plans, both within our switches and in the telephone network, any call that cannot be delivered to its designated call center is automatically rerouted to a backup center. We also have the ability to reroute calls on demand, should we need to shut down a call center before the normal end of the business day. APS believes these processes and preparation will minimize or eliminate disruption of service to the State's public plan members, and ensure the integrity of the data collected, despite brief periods of IT system failure.

To minimize the potential for data loss from computer failure, we also employ a number of preventative measures including performing complete backups at the close of business each night; storing the previous night's backup tape off-site, which is immediately available should a catastrophe occur; using a five week tape rotation so tapes up to one month old are immediately available; and storing tapes in secure off-site locations at the end of the month and never returning those tapes to the rotation.

Our corporate data center and call center are protected by a Leibert uninterruptible power supply (UPS) and a whole-building Cummins generator capable of providing 24x7 coverage of power for our telephone and computer systems, as well as a dedicated call center, during a complete power blackout. All other locations utilize an uninterruptible power supply, which allows enough time for transferring telephone lines and graceful shutdown of equipment.

**Nurse Advice Line Call Center: Disaster Recovery/Business Continuity Plan**

The objectives of Carenet's disaster recovery plan are to protect corporate resources and employees, safeguard the organization's vital records, and guarantee the continued availability of critical business operations. It defines a disaster as the occurrence of any event that causes a significant disruption in Carenet's capabilities. Carenet's disaster recovery plan minimizes a disaster's impact, whether a severe disaster (i.e., moving off-site to a back-up facility) or a less serious event such as a momentary power outage or system downtime.

The disaster recovery plan Carenet uses provides the steps necessary to be functional within 24 hours in case of a catastrophe, and during that time, allows manual processes to take place. Carenet has a comprehensive Business Recovery Team to support all facets of contingency operations.

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A high-level summary of the steps Carenet takes to ensure business continuance are:

- Assemble the Executive Committee and Business Recovery Team; these groups complete the initial assessment of damage and select the short-term and long-term plans for full recovery of all business operations including all administrative functions
- The Senior Recovery Manager and the Executive Committee will execute the disaster recovery plans as necessary
- Invoke predefined call re-routing process to immediately route all client calls to back-up locations
- Relocate any required incremental staff to handle call volume
- The Executive Management and Client Services Account Executive team will communicate with each designated client point of contact through the recovery stage on alternative options
- The Senior Recovery Manager is responsible for testing the Plan at least every two years to ensure the viability of the plan.

Given the company's operational dependency on computer and telephony systems, Carenet's Business Continuity Plan ensures the continued availability of essential services and processes. Business continuity plans have been developed for the following areas prone to interruption:

- Power Outages – for short term power outages (up to approximately one hour), Carenet uses a UPS system. A diesel generator has been installed at the Carenet facility to address long-term outages.
- Network Outages (Data and Voice) – network outages are defined as a loss of network connectivity to the site, either by an access path interruption affecting both voice and data or a long distance carrier outage affecting voice services. For data redundancy, Carenet utilizes two different ISPs and each ISP uses a different entry point into the facility. Carenet maintains alternate routing plans for all critical voice traffic. In the event of a carrier related failure, alternate routing plans can be activated to reroute calls to our back-up carrier. As part of the implementation process, Carenet would work with the State's team to establish alternative traffic routes in the event of an outage.
- Data Center Systems – the latest version of our key application software for the call center are readily available to download from our vendors. This software includes CareEnhance® Call Center System (CECC) from RelayHealth®, a McKesson company and Vertical TeleVantage®. For other essential business software, Carenet makes back-up copies of its software to ensure recoverability. Originals are stored in a secure off-site location and copies are stored on-site in a fire-proof safe. On a daily basis, Carenet runs a full back-up of critical application data and essential business applications data through a partnership with an off-site solutions provider.
- Desktop Applications – in the event that CECC is not available as a desktop application,

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Carenet has developed a manual process that can be implemented without any disruption of service and ensures the continuation of patient care.

**(h) Procedures for monitoring and ensuring the quality of services provided by member services call center staff and customer satisfaction. Please provide details about the sample size for monitoring, the type (e.g. two-way silent monitoring, one-way monitoring, taped calls, or a combination of methods).**

### **Member Services Call Center**

#### ***Monitoring Call Center Staff***

As stated in **Question 25(d)** above, to ensure our Member Services Representative meet our quality standards and expectations, APS conducts silent monitoring. Specifically, using a silent monitoring tool, calls are monitored to ensure that such parameters as greeting, confidentiality, professionalism, tone of voice, courtesy, call management, accuracy of response to inquiries, completeness of information and documentation are being implemented. The caller is always notified that the call may be monitored for quality and training purposes, and may request that the call not be monitored. Monitoring results are shared with staff and used to improve the quality of services rendered. APS will also record calls and allow remote call monitoring for the State's internal monitoring purposes. Please see **Question 25(d)** for more details on APS' call center monitoring practices.

#### ***Ensuring Customer Satisfaction***

APS monitors member satisfaction as part of our continual quality improvement process. For the State's Health Management & Wellness program, we will work with the State to establish standards for customer satisfaction for member services representatives based upon, but not limited to, an evaluation of the following areas: documentation, greeting, courtesy, responsiveness, explanation and guiding techniques, and accuracy. These elements will be captured and measured through our silent monitoring and audit process. Results will then be reported to the State on a monthly basis using a template that has been pre-approved by the State in writing.

APS also captures member satisfaction regarding our programs through satisfaction surveys that are typically completed annually. In accordance with the State's RFP requirements, APS will conduct a random phone-based, automated survey of participants in each program (lifestyle management, DM, and case management). This survey will also be offered at the end of coaching/case management calls. APS will report results to the State annually using a template that has been pre-approved in writing by the State. The report will also summarize the methodology and identify improvement activities.

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Member satisfaction surveys are conducted by our partner The Myers Group (TMG) – A National Committee for Quality Assurance (NCQA) Certified Survey Vendor. This group has provided surveys from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program; Experience of Care and Health Outcomes Survey (ECHO); and the Disease Management Association of America (DMAA—all forms of patient satisfaction surveys which have been used for Health Management & Wellness, DM and Case Management. The CAHPS Survey is often used because it yields excellent comparative, external benchmark data.

TMG employs sound methodology to secure an appropriate sample, and provide feedback on members' satisfaction with the health management program. Survey questions ask members to rate their satisfaction with a number of program aspects including overall program services; ease of administration; overall program quality; the availability of Health and Lifestyle Management Health Coaches when a member wants to talk to them; the Health and Lifestyle Management Health Coaches' understanding of the member's condition; usefulness of information (e.g., information and education provided telephonically as well as education and resource materials); effectiveness of adherence to treatment, assistance in self-management plans; and whether the member would recommend the program to others.

TMG was selected by one of APS' clients—the Wyoming Department of Health—to conduct its 2009 member and provider satisfaction surveys of the Healthy Together! Health Management Program. Noteworthy findings from Wyoming's program include the following:

- Overall 96% satisfaction rate with the information and education provided over the phone
- Overall 96% satisfaction rate with the Health Coach's or Case Manager's understanding of the Member's condition
- Overall 95% satisfaction rate with the support received from the program regarding Member's health needs.

APS will receive prior written approval from the State regarding the survey tool and methodology will be prior before October 1, 2010. APS will provide the State with a satisfaction survey report summarizing the methodology and results and identifying any activities to increase satisfaction with each program.

### **Nurse Advice Line Call Center**

#### ***Monitoring Call Center Staff***

As stated in **Question 25(d)** above, Carenet's Quality Assurance Program measures the accuracy of its assessments, effectiveness of the interaction, adherence to and meeting contractual objectives, and program results. Carenet records one hundred percent (100%) of both inbound and outbound calls. Carenet also conducts a monthly analysis of randomly selected calls and produces quality assurance reports that detail call volume, specific client issues. Program

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modifications are made based upon those results as necessary after careful review by its Quality Committee. Additionally, Carenet can provide the State with remote monitoring. Please see **Question 25(d)** for more details on Carenet's call center monitoring practices.

### ***Ensuring Customer Satisfaction***

In accordance the State's requirements, APS, on behalf of Carenet, will establish standards for customer satisfaction for Carenet's staff based upon, but not limited to, an evaluation of the following areas: documentation, greeting, courtesy, responsiveness, explanation and guiding techniques, and accuracy. These elements will be captured and measured through Carenet's monitoring of inbound and outbound calls. Results will then be reported to the State on a monthly basis using a template that has been pre-approved by the State in writing.

**C.26. Please provide responses to these same questions in the item immediately preceding this one for the nurse advice line for this Contract. In addition, for the nurse advice line, explain how, for this Contract, your nurse advice line will provide referrals to network providers, e.g., convenience clinics and urgent care centers, based on the member's location. Also, describe the process you will use for this Contract to ensure that information collected by the nurse advice line staff will be transmitted to the member's coach/case manager.**

APS assumes responsibility as prime contractor and will monitor our subcontractor, Carenet's processes. As discussed in **Question 25** above Carenet operates a state-of-the-art, URAC-accredited healthcare support center which is operational 24-hours a day, 7 days a week, providing the State's public plan members with access to care at the most convenient time for them.

Referring members to other programs provided by the client is part of Carenet's core competencies, and included in the State's Health Management & Wellness Program. Carenet fully supports engaging members in the right program at the right time. Carenet's staff is responsible for assisting your members in locating the right resource from a wide-range of options, including your external vendors, network providers (e.g., convenience clinics, urgent care centers), community-based and national resources, and public assistance agencies. We also encourage member participation in your disease management, case management, and wellness programs - the result is a healthier, happier member, while increasing the success and utilization of your programs.

As appropriate during the triage call, the Carenet nurse will make referrals to your specific programs. Carenet has implemented industry-leading software, CareEnhance® Call Center System (CECC) from McKesson, for our nurse line's clinical content and guidelines. Carenet can

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import data for your specific programs directly into its CECC system for the nurses to reference and provide referrals.

A key component of our referral process is to establish telephonic connectivity to the other programs via a dedicated phone number that allows Carenet to “warm transfer” the member exactly when they need the service. This type of transfer allows Carenet to prep the other service provider as to whom we have on the line and why we are transferring them. It also allows the other service provider to pick up the conversation where we left off so the member does not have to repeat the same story. This type of integration ensures State members a seamless healthcare experience and promotes collaboration between Carenet, APS, and the State's other vendors.

The Carenet staff will be trained on the other programs being provided by the State and will be provided with written descriptions of the programs. Referrals will be documented in our CECC system and can be routinely reported to the State.

Additionally, APS and Carenet have established protocols to ensure that information collected by the nurse advice line staff will be transmitted to the member's Lifestyle Management Health Coach/Health Coach/Case Manager. On a daily basis, an APS Clinical Manager receives daily summary sheets from Carenet on calls received from APS members. The Clinical Manager then assigns each caller to a Lifestyle Management Health Coach/Health Coach/Case Manager if they're not already engaged so that they can follow-up with the participant. Follow-up includes ensuring their needs were appropriately addressed through the nurse line as well as educating them about the wellness, disease management and case management services available to them and their benefits. For example, the Lifestyle Management Health Coach may uncover that the caller is a smoker and is experiencing a lot of stress in managing their invalid mother while taking care of her teenagers. The Coach would educate her about the Health Questionnaire as well as Lifestyle Behavior programs on smoking cessation and stress management, which she could easily access online. Additionally, nurse line staff can also warm transfer the caller directly to APS for appropriate services (e.g., disease management, wellness, etc.) after assisting them with their immediate needs.

### **C.27. Describe the preventive health messaging plan you propose to employ under this Contract. As part of this description please address all required messaging articulated in Contract Section A.11.s.**

Assisting healthy individuals to maintain healthy lifestyles and behaviors (e.g., exercising three times a week, receiving annual wellness checks/screenings, obtaining flu vaccines) is a key component of APS' program. Additionally, educating members to recognize and correctly react

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to changes in their disease specific signs and symptoms and increasing their self-management competence are critical components of our approach. With over 20 years of behavior change experience combined with our history of serving Medicaid populations, we understand that an approach using continual reinforcement of health-enhancing messages through printed, web-based, and verbal education and support generates the greatest behavioral change. We are both experienced at and dedicated to creating a health education program that equips Medicaid recipients with the information and tools they need to stay healthy and self-manage their condition. For the State, we will take a similar approach as employed in our Medicaid programs, and will accomplish this by providing members with a wide range of preventive health materials and intervention modalities tailored to their specific needs that help them sustain or improve their functionality and health status. APS will deliver health messaging through a multi-media campaign of printed materials (mailed postcards and site posters), e-mail blasts and telephonic outreach via IVR technology.

In accordance with the State's requirements, the annual preventive health messaging plan will include:

- **Monthly preventive messages** that focus on a specific condition or service (entire population) sent via mail and telephonic messaging. Content will include general wellness issues identified by the State (e.g., seasonal allergies, flu vaccinations).
- **Targeted Messages** (members identified with a specific condition/need for a specific service based on information provided by State) sent via mail and telephonic messaging. Content will vary based upon State's needs to help members understand their condition or screening needs and offer ways to improve their health (e.g., medication management, nutrition for diabetics, common cancer screenings, etc.).
- **Periodic, population-based messages** (entire population) sent via mail, email, telephonic messaging. Content will vary (e.g., weight management, tips for a healthy heart, healthy eating, exercise, safety, stress management, cholesterol management, tobacco/smoking cessation, skin protection). Poster content will also coincide with and support the four (4) wellness challenges as well as other events (e.g., health screening events).
- **Preventive Services Reminders/Postcards** (entire population) sent annually via mail. Postcards will be based upon preventive health services that should be followed in accordance with the member's age/gender that are consistent with national guidelines. (e.g., mammogram, prostate exam).
- **"Tip of the Week"** emails (entire population). Content will vary based upon State's needs and preferences.

A graphic of our plan is provided on the following page.

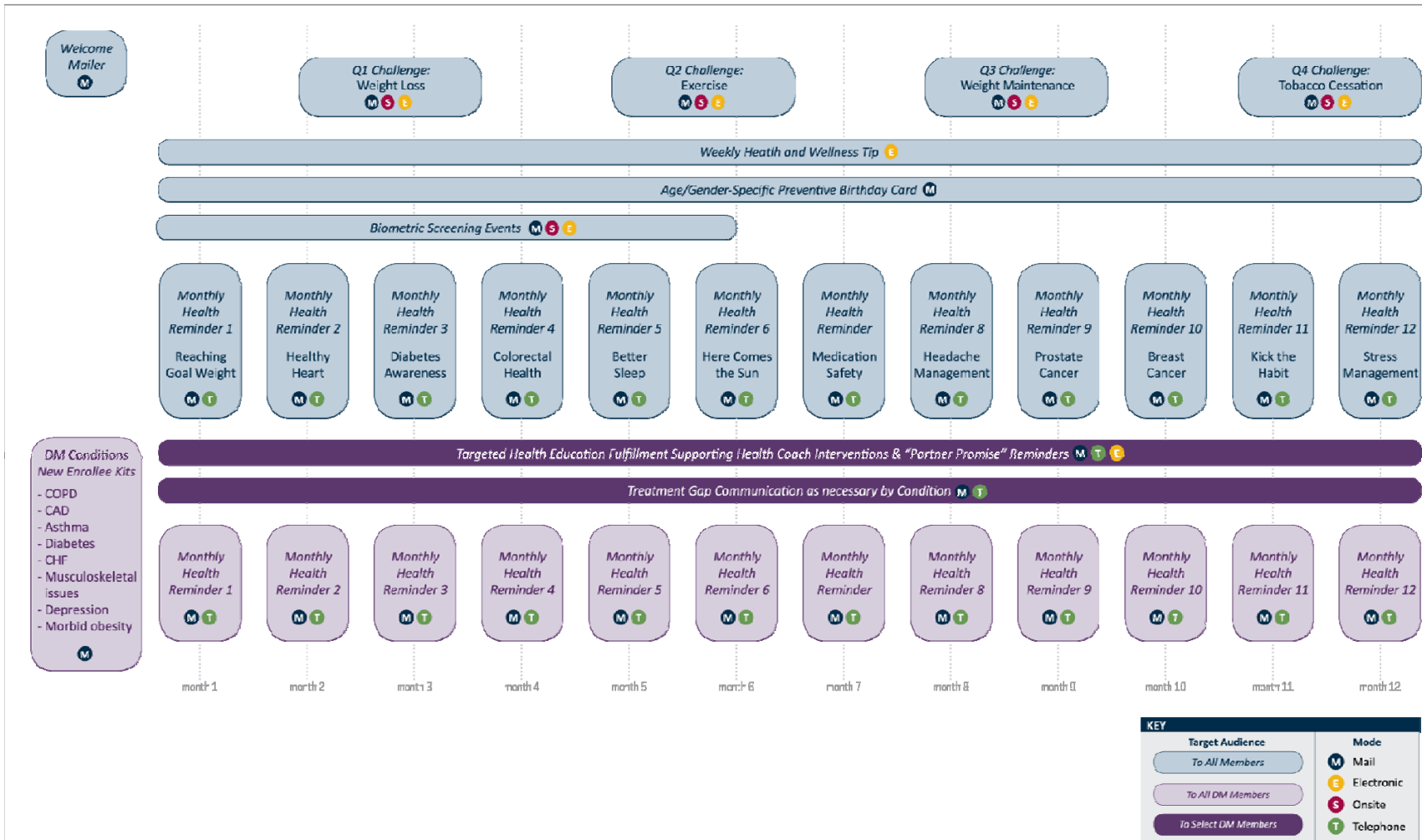
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# A Proposal to the State of Tennessee to provide Health Management and Wellness Services to the State's Public Sector Plans

RFP No. 31786-00105

## ParTNers for Health Program Member Communication Plan



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The plan will comply with all program requirements as stated Contract Section A.11. Member Education and Outreach. The plan will also include a description of when email will be used and when postcards or other print media will be employed. APS will submit the plan for the first plan year for review and prior approval by the date specified in Contract Section A.22.

## **Printed & Electronic Messaging**

APS has an extensive library of materials which we will adapt for use for the State's program and that can be used to deliver your monthly preventive messages, monthly targeted messages, population-based messages, and preventive reminders. Information is developed and conveyed in a manner that members can trust, easily understand and that provides actionable information that is culturally competent and available in additional languages such as Spanish. Materials, which will be branded with the State's "ParTNers for Health" logo, will also include APS' toll-free program number, hours of operation for the member services call center and nurse advice line in large, bolded typeface. Sample preventive messaging materials are provided in **Exhibit N**.

## **Telephonic Messaging**

Through an Automated Telephonic Outreach (IVR) technology, APS currently utilizes outbound messaging to contact members with a personalized message containing important health information. We use automated telephonic outreach calls for over 40 campaigns ranging from engagement in Health Coaching programs to diabetes reminders. For the State's Program, APS will use this technology to deliver monthly preventive health messages, monthly targeted messages for those with specific conditions or in need of specific services based upon information provided by the State, as well as periodic population-based messages. For example, based on ongoing data analysis as well as results from the health questionnaires and health screenings, we will identify individuals who should receive calls for specific targeted campaigns. If awarded this contract, APS will consult with the State to decide which areas to focus on, the timing and frequency of campaigns, and language to use to ensure that our approach is aligned with your objectives and expectations.

Automated Telephonic Outreach messages can be automatically delivered at any time we choose, including evenings and weekends. Members who receive a message can utilize touch-tone response options to ensure crucial two-way communication. The Automated Telephonic Outreach system employs a human voice when calling members, maintaining a personal touch, and can relay a unique set of response options, including:

- Call transfer to a Lifestyle Management Health Coach/Health Coach/Health Promotion Coordinator
- Language preference
- Repeat message

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It also supports multiple languages and can define conditional filters for automatic message assignment. For example, Spanish-speaking members hear Spanish messages and elderly members hear louder messages. Message mapping means that State members will always receive the correct message.

**C.28. Describe in detail the process and procedures that the Proposer will follow to ensure that the reading level requirements of Contract Section A.11.I. are met. To the extent that current Proposer materials do not comply with the required standards, include a comprehensive explanation of the proposed approach for revising them to read at or below the 6.0 reading level.**

APS rigorously reviews materials to ensure they are clear and reader-friendly for all of our program audiences. In fact, all of APS' printed health education materials are already written between the fourth (4th) and sixth (6th) grade reading levels. For all of our programs, we use the Flesch-Kincaid method to score reading level and reading ease; as a result, our materials are written for reading levels between the fourth (4th) and sixth (6th) grade and a reading ease score between 80 and 90 (easily read by 10-11 year olds). We are more than happy to submit draft materials as well as a reading level analysis and certification of the reading level of each piece of material to the State. APS ensures that all current and future printed education and outreach materials for your public plan members will meet your reading level requirements.

**C.29. Describe the specific information systems that the Proposer will use for this Contract.**

### **APS CareConnection**

As stated in **Question C.17** above, APS will employ our innovative, proprietary, HIPAA-compliant, web-based system solution, known as APS CareConnection, to effectively deliver the State's Health Management & Wellness Program. APS CareConnection integrates information across various providers and sources (e.g., physician offices, hospitals, health plans, pharmacy benefit managers, health questionnaire vendors, specialty laboratories, medical management companies, employee assistance programs and behavioral health providers). CareConnection offers capabilities such as decision support, online evidence-based guidelines, and other tools for the provider community. CareConnection is linked throughout all of our internal departments and is able to seamlessly integrate eligibility, clinical claims, encounter claims, pharmacy claims, health questionnaire results, health screening (biometric) data, wellness activity, information gathered from members and providers, quality improvement efforts, and supplemental data we receive from the State.

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APS CareConnection is also compliant with many NCQA standards allowing APS to achieve its accreditation that much easier. As shown in **Exhibit U**, APS CareConnection meets element standards for Case Load Management, Client Demographic and Eligibility Information, Patient Dashboard, Episode Level – Outreach Activities, View All Notes, Provider Screen, Assessments, Individualized Plan of Care, My Follow-Ups, Activity Interaction Documentation, Individualized Treatment Plan, Education Module, Provider Portal to Support Client Activities, Plan of Care and Secure Messaging APS has provided additional information regarding our information system platform, technology and tools that will support the delivery of the State's Health Management & Wellness program in the following paragraphs.

## System Overview

The APS IT environment is mature and robust relative to industry benchmarks. The technology infrastructure in use throughout APS is based on industry standards and best practices. An enterprise architecture team maintains ownership over the enterprise frameworks in use, regularly updating, measuring and improving the infrastructure to enable IT to meet customer requirements faster, better and more cost effectively. APS IT uses an enterprise architecture framework which incorporates the best practices from numerous leading frameworks, including FEAF and TOGAF.

Using defined measurements and metrics as the guide, the IT environment has the following attributes:

- Industry standards based in all sub-architectures
- Best practices and frameworks-based, including TOGAF, ITIL, COSO, CobiT and CMMI
- Managed with discipline governance processes & routine controls reviews
- Emphasis on collaboration and knowledge management
- Focus on agility and scalability to keep customers costs down
- Obsessive commitment to risk management, privacy and security

## Applications Architecture

The Applications Architecture is the heart of the IT delivery engine, consisting of the applications, integration & delivery processes for IT-based solutions. The development and delivery process is based on industry-standards to enable the organization to deliver quickly and cost effectively. The following attributes describe the applications architecture:

## Multi-platform

The delivery team has the capability to support the best platform for the customer, from desktop to Windows Server to Unix-based server solutions.

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## **Agile**

The solutions developed are built with significant self-service configuration, allowing the business to configure the solution to meet customer requirements thereby reducing the amount & time of IT investment needed. Additionally, by following industry standards APIS & technologies, IT is able to quickly integrate solutions.

## **Methodology**

The IT organization operates on defined, industry-standard processes & methodologies, selecting the appropriate process for the situation. Example methodologies including the use of a Project Management Office (PMO), PMI-based project management methodology, RUP-based waterfall development methodology, and SCRUM-based iterative development methodology.

## **Quality Assurance**

All processes & releases go through a discipline QA process, including the use of a dedicated QA organization.

## **Data Architecture**

APS has a world-class data architecture, leveraging the extensive skills of experienced data architects. All data is managed through an Enterprise Information Architecture, which is focused on movement, management, enrichment and consumption of data. APS employees Data Quality Management (DQM) for ensuring, maintaining and improving the quality of data as it flows throughout the organization. The following attributes describe the data architecture:

## **Architected**

Data & information flows through applications using a purposeful, managed approach that takes the enterprise into account to maximize the value and structure of data. Data is fed into an Operational Data Store using ETL tools and applying semantic resolution, then structured in Data Warehouses for analytics & reporting.

## **Security**

Given our commitment to members and patients, privacy & security information is managed by SLAs, auditing and metrics development which appropriately measures confidentiality, integrity and availability (CIA). Preventive, Detective and Corrective security controls are used to assure security of information.

## **Performance**

The APS data architecture is architected to support very high volumes of data with excellent system performance and responsiveness which increases staff productivity.

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## **Privacy & Security Architecture**

APS is obsessive about security & privacy. APS actively maintains awareness and training programs around privacy and security. All employees are trained on privacy and security fundamentals; including HIPAA and preempted state regulations/laws where they preempt Federal regulations/laws with regular awareness updates for reinforcement. APS has extensive documented policies governing processes that deal with all types of information, including PHI. A security organization staffed with certified security professionals develops and maintains policy, audits compliance, and oversees implementation based around NIST Standards. All internal and external systems are hardened with industry standard security solutions.

## **Systems Management**

The systems management architecture for APS is based on ITIL best practices. The data center employs best practices for security, operations and resilience. Numerous industry standard technologies are deployed in the data center, including environmental control systems, Tivoli systems management solutions, business continuity & site recovery, and monitoring and alerting.

## **Telecommunications Architecture**

The telecommunications infrastructure consists of industry standard equipment & providers, e.g. CISCO, Avaya, AT&T, etc. The overall telecom infrastructure is built on a high availability, fault tolerance framework on top of an MPLS. The architecture supports multiple protocols as necessary to support customer needs, such as FTP, S-FTP, S-MIME, Web-SSL, VPN, etc. Redundancy and fault tolerance is implemented per defined Service Level Agreements. All APS sites are connected via the MPLS to a high-speed backbone-based server infrastructure.

## **Physical Architecture**

APS supports a multi-platform physical architecture at the server level. All servers are rack-mounted with managed interfaces in a controlled environment. The APS infrastructure focuses on maintaining a low Total Cost of Ownership and high Business Resilience. Industry standard technologies are deployed, including virtualization, blade centers, distributed power management, enterprise storage management and enterprise backup. The vendors of choice are IBM and Dell for Intel & UNIX-based systems. The data center is located in Brookfield, Wisconsin, a suburb of Milwaukee.

## **Business Resilience Framework**

APS has implemented a Business Resilience Framework (BRF) to address the typical concepts of Business Continuity and Disaster Recovery Plan. The objective of the framework is to align the resilience of the infrastructure with the SLAs and operational risk of the business and its customers. The goal of resilience is to ensure availability of the infrastructure, with solutions

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and processes that either absorb incidents without fault or apply secondary measures to address unavoidable faults.

The BRF plan addresses the three core aspects of business impact, including emergency response (e.g. bomb threat), crisis management (e.g. theft) and business continuity (e.g. telecommunications failure). The ultimate goal of the plan is data continuity for customers. SLAs are extracted from customer commitments to provide the operating guidelines for all aspects of the infrastructure. Plans are defined, maintained and regularly tested to address the various incidents which may occur. After incidents occur and are resolved, groups meet to perform an analysis of the situation, with the focus on continually improving the BRF based on actual results.

### **Specifically address:**

#### **(a) any modifications to existing hardware and software that will be required;**

We can assure the State that this system currently provides functionality that meets your scope of work and requires no significant modifications to existing hardware or software. We will configure this system during implementation to include specific Plan eligibility specifications, condition-specific plan of care algorithms, and links to the State's sites.

#### **(b) the extent to which these information systems are already in operation;**

APS' information systems, including APS CareConnection, are already in operation for many other health management and wellness customers including the State of Ohio for example.

#### **(c) the timeframe for any implementation of components not currently in operation; and**

All the primary program components necessary to administer the State's Health Management & Wellness program are currently in place. APS ensures that all components not currently in place will be operational by the go-live date of the State's Health Management & Wellness program.

#### **(d) the capabilities and the expertise of the staff/personnel dedicated to support information system operations.**

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The APS Information Technology (IT) department, under the leadership of Greg Flanagan - Chief Information Officer, is an integral function at APS, which is dedicated to supporting our information system operations. A department of 160 information technology professionals, APS IT has three established units: administration; infrastructure and operations; and applications development. Each unit is led by an industry expert - Joseph Steele is Vice President of Administration; and Amir Segev is Vice President for IT Applications. Biographies detailing the expertise our IT leadership is provided below.

### **Greg Flanagan, Chief Information Officer (CIO)**

Based in Nashville, Tennessee, Gregory Flanagan is Chief Information Officer for APS, responsible for all technology development and support initiatives. His leadership in the deployment of key technologies, including the company's state-of-the-art CareConnection® system, is a key factor in driving improved efficiencies and greater health outcomes for APS clients throughout the nation.

Prior to joining APS, Greg served as Chief Information Officer at MRPKCH, LLC, where he developed technology strategies to more effectively support healthcare operations that included outpatient physical therapy services and ambulatory surgical centers. Earlier, Greg held the position of president at XMi Technology, a unit of Xebec Management, Inc., where he managed technology operations for the company and its operating divisions.

Past technology leadership positions include president of InfoAdvantage, Inc., one of Nashville's largest technology services firms serving healthcare providers and professional services organizations; senior program manager for healthcare and enterprise solutions at SAIC, a global provider of information technology solutions; vice president at Theraphysics Corporation; and roles at HealthTrust, Inc., where he managed the company-wide implementation of a financial decision-support system for the \$3 billion corporation.

Greg is a member of the Healthcare Information Management Systems Society, and he is the volunteer regional director for the Miami Project to Cure Paralysis. He earned a bachelor's degree in economics and a master's degree in health administration, both from Duke University.

### **Joseph Steele, Vice President, IT Administration**

Joseph Steele is the Vice President for IT Administration at APS. He is responsible for managing the corporate-wide IT governance process for all APS business groups with several functional areas: IT security, governance and controls and the Project Management office. Joe leads a team that focuses on creating measurable and effective policies, controls and metrics in support of project delivery, budgets and compliance.

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With over 17 years of experience, Joe has managed IT functions with a heavy concentration in Infrastructure, Client Services and Project Planning. His specialties include extensive SOX experience creating and executing IT general controls and working with internal and external auditors. Joe has significant vendor management experience managing contracts, engagements and supplemental staff preferred pricing models.

Joe's past leadership positions include Senior Director, Information Systems at Regeneron Pharmaceuticals; Director of Technology Integration, Planning & Support at Schering-Plough; and Vice President, Network Operations and Infrastructure at Enhance Financial Services. Joe holds a Bachelor's degree from The College of New Jersey.

### **Amir Segev, Vice President, Application Development**

Amir Segev is Vice President of Application Development for APS Healthcare. He has leadership responsibility for business analysis, application planning, enterprise architecture, and software development and implementation, supporting care coordination and delivery via member-centric technology solutions. Amir has over 20 years of experience in information technology with an emphasis on developing IT solutions for healthcare. Prior to joining APS, Mr. Segev worked for Merck-Medco, Cigna Healthcare and CareFirst BCBS in various leadership roles. He holds a B.S. in Computer Science/Business Administration from Ramapo College in New Jersey and is a Certified Computer Engineer through the Israeli Defense Force Computer Academy.

### **William Turner, Chief Security Officer (CSO)**

William Turner has held positions in both IT healthcare and Privacy/Security senior management. He has over 12 years of experience in managing IT healthcare in covered entities, including provider and health plans. Bill has served on the Chief Privacy Officer Council for a 90-county hospital system in Texas and on the board of the HIPAA committee for the North Texas Hospital Association. He has over 17 years of experience in all facets of IT management, including running security teams, development teams, network engineering teams, project management offices, IT Operations, helpdesks, and database administration.

Bill started his career as a certified social worker in the state of Texas working in both the public and private sectors. He spent six plus years in the defense industry in an AFEWES/Old Crow environment working in secure electronic warfare and computer warfare environments. He has held a secret clearance and managed tempest controlled data centers. He was the implementation director for HealthVision (a Voluntary Hospital of America (VHA) company), a secure Medical Health Portal for 1,800 hospitals and 9,000 physicians. He also served as the Director of Strategy for a healthcare system where he implemented both the privacy and security program.

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Bill holds certifications as a Certified Information Privacy Professional – US Business (CIPP), Certified Information Privacy Professional /Government (CIPP/G), a Certified HIPAA Security Specialist (CHSS), and a Certified HIPAA Professional (CHP).

APS staff members hold advanced degrees in information assurance, CISSP certification, Security + and certifications in numerous operating systems and infrastructure components. Staff members also hold membership in Information Systems Security Association, International Society of Forensic Computer Examiners, the FBI's "InfraGard", International Association of Privacy Professionals, Computer Security Institute, Health Information Management Systems Society, and other organizations.

### **C.30. Describe or provide the following information regarding data integration and technical requirements under this Contract:**

**(a) the ability to ensure the accurate and timely processing of enrollment files including eligibility additions, changes, and deletions based on a standard 834 file supplied by the State as described in Appendix 7.7.;**

APS is extremely experienced in establishing accurate and timely data integration and data exchange protocols as we do so with each of our customers, and can do the same for the State. We have a long history of successfully establishing file transfer protocols that both comply with each contract's requirements, as well as the latest HIPAA regulations regarding security and confidentiality. As part of our standard operations, we accept various types of data (e.g., claims, eligibility, provider, authorizations, etc.) from our customers in order to effectively administer their specific programs. Database management and data exchange functions are overseen by our Information Technology Department to ensure all data is received in a timely manner and that data is in an acceptable format for analysis. As a result, APS is more than able to accept data, including enrollment files, from the State and your other vendors.

In addition, if the process for data transfer at initial implementation is handled through one method and later may need to be enhanced or altered, we are fully prepared to incorporate these changes as needed. Our preferred data exchange method is SFTP. In order to access the State's enrollment files, we confirm that we will design a solution, in coordination with the State, to connect to the State's Secure File Transfer Protocol (SFTP) server. We will then download the file and decrypt the file in its secure environment.

As changes in enrollment occur, our system updates the information within one (1) business day and reconciles the active membership. Our MIS system is sophisticated in that it can differentiate between additions, changes, and deletions and thus, performs the required action appropriately. For example, with regard to changes, when our current program recognizes an

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existing "Member\_id," it archives the old information and then inserts the new information. If a required piece of information is missing, the record will error, "no member record exists," and will be identified in our error reports so that we can reconcile the issue.

While we don't currently receive data from BCBS of Tennessee specifically, we have established effective data exchanges with a number of other Blues plans as well as fiscal intermediaries, external vendors and state agencies across our numerous state health and wellness and Health Management & Wellness programs. Details of our experience include but are not limited to the following data exchanges with other Blues plans:

- APS accepts monthly claims data from BCBS/Anthem for customer, General Cable.
- APS accepts monthly claims data from Wellmark BCBS for customer, Iowa Laborers.
- APS accepts weekly eligibility and claims data from BCBS of Missouri for customer, Laclede.
- APS accepts monthly claims data from BCBS of Illinois for customer, Lake County.
- APS accepts weekly claims data from BCBS of Montana for customer, MCHA.
- APS accepts weekly eligibility data (updates) from BCBS of Montana for customer, MCHA.
- APS accepts monthly claims data from BCBS of Alabama for customer, a large energy customer.
- APS accepts monthly claims data from BCBS of Georgia for customer, a large energy customer.
- APS accepts weekly eligibility data (updates) from BCBS of Montana for customer, the Plan of Montana.
- APS accepts monthly claims data (updates) from BCBS of Georgia for customer, UFCW Atlanta.

Below we have provided additional examples of our data exchange successes with other contracts— all of which use an automated SFTP site methodology:

- Accept monthly eligibility data (full) and monthly claims data from a large BCBS Plan customer in the West.
- Accept monthly eligibility data (full) from the State of Hawaii SMI
- Accept daily eligibility data (update) from the Government of Puerto Rico
- Accept weekly eligibility data (full) from the State of West Virginia
- Accept daily eligibility data (update) from the State of Maryland
- Accept daily claims data from the State of Maryland
- Accept weekly claims data from the State of Georgia
- Accept daily authorization data from the State of South Carolina
- Accept daily authorization data from the State of Georgia

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- Accept daily authorization data from the State of Hawaii SMI

**(b) the quality control processes that will be used to ensure the accurate and complete update of eligibility files as well as how eligibility errors will be communicated to the State; and**

APS has quality control processes in place to ensure the accurate and complete update of eligibility files. We have implemented a state-of-the-art solution using leading industry solutions to process external heavy data set, including eligibility files. These processes run daily during the agreed upon Service Level Agreements for each individual file and immediately processes on its arrival. All incoming and outgoing files go through numerous error and standardization checks before data is available as information in downstream applications. The system maintains the audit trail of every record for any changes to data during its lifecycle. As part of data quality control, APS applies sophisticated processes within our infrastructure to standardize and enrich the data being imported by leveraging the USPS standard address data that we receive quarterly from Melissa Data® (third party data provider) for validating postal addresses and standardization of phone numbers. As part of this data cleansing and enrichment process, we have the ability to track and report incomplete, incorrect and inconsistent data back to the sender (the State) as part of reconciliation process.

In accordance with the State's RFP requirements, APS will retrieve, via the State's SFTP site weekly enrollment files in the State's Edison 834 file format. APS agrees to post ninety-eight percent (98%) of electronically transmitted enrollment updates within one (1) business day of receipt of the Weekly Enrollment Update and to post one hundred percent (100%) within three (3) business days of receipt of the Weekly Enrollment Update.

APS will communicate eligibility errors to the State. This includes completing and submitting a Weekly File Transmission Statistics Report via email to the State within twenty-four (24) hours of receipt of the Weekly Enrollment Update. Additionally, APS will resolve all discrepancies identified by the processing of the Weekly Enrollment Update within five (5) business days of receipt of the file from the State. We will work with the State to develop a process for responding to invalid or non-processed records. This may include communicating directly with the State as we load the enrollment file to ensure we have the same data in real time.

**(c) the process for loading historical data from the current claims administrators and validating the completeness and integrity of said data, if applicable.**

APS prefers to receive monthly claims data through a SFTP site, which can be downloaded and then uploaded into our system. As part of our normal data exchange protocols, APS validates

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the completeness and integrity of all imported data, including historical data from the State's claims administrators. All our claims data is loaded into APS' Data Warehouse for downstream integration and reporting needs. During the load process into our Data Warehouse, all claims data including the history data goes through multiple stages to primarily check for claim validity (e.g., date of service, procedure codes, diagnosis codes, drug codes and other reference data, place of service, bill type, type of service). During the load process, the system also links the claims record to valid eligibility member data. Any record failing the validation test is flagged for error with error description and an Exception report is generated for all rejects. The valid claims information is then fed from our Data Warehouse into APS CareConnection for access by our Lifestyle Management Health Coaches, Health Coaches and Case Managers; Health Intelligence staff for analytics; and Business Intelligence staff for reporting.

APS will work with your current claims administrators to establish and maintain systems and processes to receive and provide all appropriate and relevant data regarding the State's public plan members.

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